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QUARTERLY MAGAZINE

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PSYCHIATRY FOR EVERYMAN IN HIS EVERYDAY LIFE *

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ABOUT psychiatry, this one thing may be said without fear of contradiction—that it engages the public's interest far and above any of the other medical specialties.

Psychiatry has indeed become a popular commodity.

What is more, every one is horning in on this newly discovered domain. The playwrights, the oldest among the psychiatric brotherhood, have rediscovered the subject, and they have regaled us with overgrown rabbits, the bosom friends of inebriate gentlemen, and with *Shrikes*, who paint the fury of "woman denied." *The New Yorker* would be a dreary sheet were it not for its cartoons spoofing the psychoanalyst. Even the postprandial orators are nowadays more likely to open up with a yarn about a psychiatrist than with the old chestnuts about the traveling salesman, the farmer's daughter, or "the Irishman by the name of O'Toole"!

A spate of books on psychiatry have been published, written for every breed, age, and condition of reader. There are books written by those who "went through it" to tell those who haven't "just how it feels to be analyzed," and what it does for you. There are a score or more of popular magazines devoted entirely to psychological themes and problems, and their readers run into the millions.

How is one to account for the public's consummate interest in psychiatry?

* Presented at the One Hundred and Eighth Annual Meeting of the American Psychiatric Association, Atlantic City, New Jersey, May 12, 1952.

Certain explanations come at once to mind—explanations that are advanced, one must suspect, by the bigoted and the ignorant. *They* say that psychiatry appeals to the prurient—that it deals with sex, with sexuality, and suchlike intimate items, which in decent society are discreetly hidden. This “explanation” explains nothing. Psychiatry for certain deals with sex and sexuality, and with other intimate phases of the living experience, but any one attending a psychiatric lecture in the expectation that he will there witness an academic burlesque, or watch what in effect might prove to be a mental and emotional strip-tease act, is most surely bound to be disappointed.

It is also said that psychiatry appeals to those with a penchant for the morbid—that healthy, normal people do not bother about their psyches. But this is akin to the comment credited to the skeptic who, on learning that his friend was considering psychotherapy, exclaimed: “What! You want to go to a psychiatrist? My dear boy, you should have your head examined!”

If interest in psychiatry is to be taken as a negative index of well-being, then we'd have to admit that “an overwhelming number of people are neither well nor normal.” But of course that's nonsense. It is not true that psychiatry appeals to the morbid, nor does psychiatry itself deal entirely or exclusively with morbidity. Psychiatry, like all of medicine, began with the sick, with the pathological, but out of its experiences with disease it has forged an understanding of health and of healthy function. Like all of medicine, psychiatry now aims also to indoctrinate people in normal psychophysiology in order to help prevent psychopathology.

Other explanations are advanced, equally futile and irrelevant, some of which I will touch on as I develop my argument, but none of those easy explanations really explains why the average, educated, intelligent, and well-informed man and woman, the young, the mature, and the advanced in years, are so keenly interested in psychiatry.

The immediate reasons for the public's interest in psychiatry seem to me to be simple enough. In some respects, people are bewildered, confused, uncertain, and uninformed. They turn to psychiatry in the expectation and hope that thereby they may find orientation and illumination. They turn to psy-

chiatry for knowledge and for understanding in matters that are of great importance to them, matters that involve intra- as well as interpersonal relations—relations between parents and children, between men and women, between young and old, between subordinates and superiors, between desire and duty, between egotism and altruism, between hedonism and conscience. Many turn to psychiatry seeking insight into life's meaning, and a gauge to human values. Many who are not sick are yet troubled for want of ease and inner security. Some, no doubt, are curious about psychiatry for more urgent reasons, because they are at odds with themselves and with the world about. They hope psychiatry will show them "a way out."

These are, to my mind, some of the components of the basic reason why people are so deeply interested in psychiatry—because many among them are bewildered, confused, uncertain, and uninformed.

This, however, raises another and, in some respects, an even more troubling question. *Why are people "confused, bewildered, uncertain, and uninformed"?* And this further leads to a correlated question usually framed thiswise: "How did our great-grandparents get along without psychiatry and without psychiatrists?"

Though this is usually asked in skepticism and with an implied disparagement, it is, nevertheless, a pertinent question, for it strikes at the very core of the matter. Yet the answer to this question appears to be simple enough: the world we live in differs radically from that of our great-grandparents. It is more than likely that, did they live now, they, *too*, would be confused. They would be confused because they could not find to-day the institutions, the social trusses, and the patterns that instructed, guided, and sustained them in *their* days.

To say that the world we live in differs radically from the world of our great-grandparents is to voice a something that rings like a cliché and is all-too-easily misconstrued. Every schoolboy knows that our great-grandparents lived in a world that was without the telegraph, the telephone, the radio, the electric motor, the gas motor, the automobile, the aeroplane, television, vitamins, antibiotics, and so on. Every schoolboy knows that, and not a few among them, grown up a bit, know

also that the wear and tear, the strain, the rush, the competitiveness of to-day were unknown to our ancestors.

But significant as these matters may be, they are not what I intend when I underscore the difference between our world and that of our great-grandparents. I mean, rather, specifically related, but, to my mind, more significant, "changes." I mean, to name them categorically, the disappearance of the homestead, the ousting of the woman from her nuclear position in the home and family, and the weakening of the power and influence of those institutions whose historic mission it is to indoctrinate man in the habitudes and practices of altruism. These changes are in many derivative ways related to what we commonly term the Industrial Revolution, the rise of modern capitalist society, and the growth of modern science.

The standard texts that treat of these revolutionary changes do not, to my knowledge, deal with the homestead, woman, or religion, or, treating of them, grossly misconceive the quality of the changes that were effected. Everything is seen through the rosy-tinted delusion of "progress." The patriarchal homestead, we are instructed, has given way to the modern apartment, with all its conveniences, and woman's drudgery has come to an end, thanks to the washing machine, the dishwasher, and the frozen-food counter. And as for Church and Religion, we are advised that modern science has made them both rather superfluous.

I do think it will more than repay us to look closely at just what did happen to the homestead, to woman, and to our religious and ethical institutions, and to observe further what bearing all this may have on current popular interest in psychiatry.

First, as to the homestead. I employ this term in a singular sense. I mean by homestead a place where commonly three and sometimes four generations lived together, at times in one house, more often in a cluster of houses in close proximity. Whatever the disadvantages of such close living might have been—and our novelists are fond of portraying them—there were certainly also some great advantages, so that one who grew up as the member of a homestead learned a great deal about life, and about life's ways. For if the family was large enough—and families usually were—he had before his very eyes a sustained parade of births and deaths, of courtships,

matches, and marriages, of successes and of failures, of good and bad relations, of quarrels and reconciliations, of frustrations and attainments—in effect, of all the tints and shades in that spectrum of feeling, thought, and wisdom that is encompassed in the arc of a full life. But now the homestead has all but disappeared, and so, too, has the opportunity to learn, by intimate experience and observation, much of the skill and wisdom that is requisite to effective living. And we have not as yet developed or cultivated any adequate substitutes.

The story is frequently told of the poor little city-dwelling child who thought milk just naturally "comes" in bottles. There are many more—and they are not limited to city dwellers—who have never seen a woman suckle a child, an infinite number who not only have not witnessed this simple act, but who could not, try as they might, visualize the concomitant satisfaction of the woman and the contentment of the child.

It may seem odd to affirm that in this "age of free necking" there are many young who do not know and cannot comprehend courtship. But such is the case, for they have never had the opportunity to observe it, or to witness it. One can pursue this catalogue of deprivations right through the full range of life's conditions and experiences. Men and women who have had no intimate contacts with infants or children until their own first-born was placed in their faltering hands; the wedded young who do not know that the sea of matrimony is only occasionally pacific, and who in every familial storm anticipate a shipwreck; young men and women who come to adulthood with romantic preconceptions, gleaned from novels, the movies, and the radio, and who do not understand that living together calls for the constant reconciliation of innately legitimate and normally divergent drives, interests, and viewpoints.

When the homestead was the prevailing pattern of communal living, one could acquire life's requisite wisdoms and experiences as one acquired one's mother tongue, without deliberate effort and without awareness. But now such sources of instruction are largely limited—and people perforce turn to psychiatry.

Those socio-economic forces which effected the disintegration of the homestead also dislodged woman from her nuclear position in the home and thereby produced a most disruptive change in the constellation of the family. Once the mainstay

of the familial aggregate, its most indispensable member and most valued and protean servant, woman has been degraded to the status of an "equal"—that is, equal to all liabilities, and exempt from no exactions. As the song now has it, woman has become "a some-time thing."

Much has been written about the social changes that followed in the wake of the Industrial Revolution—the growth of the city and the spread of its slums, the creation of a degraded and impoverished proletariat, the rise of child labor, the loss of the crafts and the skills of the hand worker, and so forth. But to my mind two consequences of the Industrial Revolution have received but scant attention despite the fact that they have had the profoundest and most far-reaching effects upon the human race. One of these concerns man's food and diet; the other, the position and function of woman in the family. I cannot here treat of those most disastrous alterations in man's diet that were consequent on the Industrial Revolution—alterations that more than any other factor were responsible for what the Germans termed "*Zivilisationsseuche*," the plagues of civilization—typhoid, cholera, tuberculosis, rickets, chlorosis, diphtheria, scarlet fever, scurvy, and pellagra, to name but a few. I must rather concern myself with the second consequence, the degradation of woman's position and function in the family.

For many scores of thousands of years woman was the *fons et origo* of the family. She was wife and mother, nurse and teacher. She spun the yarn and wove the cloth. She tailored; she gardened for the kitchen and the medicine chest; she it was who molded candles, preserved foods against the winter seasons, made soaps, cooked, baked, laundered, and tended to the hundreds of functions and details that are so vital to the maintenance and welfare of the family.

She, above all, bore sons and daughters, to be of aid to herself and their father, to be their pride, their consolation, and their support. Doubtless she worked long hours and hard, but for all that she had her rewards, the greatest among them, the secure knowledge that she was needed and wanted, that she was indispensable in the scheme of the living pattern. There was for her, too, the sense of accomplishment, the satisfaction that comes with the fulfillment of the primal urge to create and to dispense of self in the process.

Thus it was for countless scores of thousands of years, and it was already an ancient wisdom that found utterance in the couplet of the Proverbs:

“A good wife is a crown to her husband;
But one who acts shamefully is like rot in his bones.”

And in The Words of Lemuel:

“If one can find a good wife,
She is worth far more than corals.”

All of this, however, has been changed, with and since the Industrial Revolution. One after another of her functions, of her utilities in the home, have been taken from her, first by the machine, and then also by the mercantile, commercial, and social agencies. Now she neither spins nor weaves. She has neither greens nor herb garden. She does not bake, though she may yet cook. In a word, as some of our feminist and liberal friends say eagerly, she has been freed from the yoke of household chores. She is a free woman! Free for what? Free of her last and ultimate reason for being, to bring forth new life!

Time past, sons and daughters were the precious material, no less than spiritual, assets of a life fully achieved. To-day, children are often an economic drain and an emotional liability. Not that the love of a child, its gay laughter and troubled tears, will less touch our sentient hearts this day than before. Rather it is that the companionship of fathers and sons, of mothers and daughters, has less amplitude, less pertinence to-day, when father is at the office or in the factory, than when garden and field, workshop and home, offered a thousand occasions for the doing of things together. City dwelling affords no opportunity for “growing up together”; it provides not for the doing of chores—those practice tasks of the young that in years past served as the prelude to the adult’s rôle in life—man and woman alike.

To all this the carping critic might say, “Well, you know life does change!” That’s true, yet it is relevant to establish just what we mean by life. The external and the environmental do change. The essentially biological does not, at least not so that we can perceive it in our own experience.

The socio-economic changes dealt with have taken place in our sphere within the last one-hundred-and-fifty years. This

is but as a moment in the long span of man's habitation on this globe. We then must ask: Can the primal hungers and wants of men and women be readapted to fit this changed and changing world? Can we with impunity deny, gainsay, block out, impede, divert, that *élan vital*, that upsurging drive that lifted man out of the primal ooze and that has through the aeons of time brought him to the forefront of creation? Can we, without paying a fearful price, therefore, meddle with that order of relations between men and women that has in the span of time yielded us love and song, the plastic arts, poetry, the dance, the culture of beauty, of form and color, of adornment, of perfume; that has given us courtesy and grace, manners and spirit, that has fostered home and friendship, and the strong bonds of blood kinship, the *Anlage* of all that is civil and civilizing? Can we? All the available evidence speaks against it: witness the so-called Battle of the Sexes, "Hate and Love," and "Momism."

To the man from Mars—for he alone could be considered a true outsider—it would appear that woman, so largely deprived of her God-given prerogatives, is seeking retribution in a frenzy of aggressions and frustrations. I will not attempt to catalogue them. I need only note them, and thereby give one added account of the reason why so many thoughtful, earnest, and troubled men and women are interested in and turn to psychiatry.

Now I need turn to the third major change that so markedly distinguishes our world from that of our progenitors—the decline in prestige and power of those institutions whose primary function it is to indoctrinate man in the habitudes and practices of altruism. I mean primarily religion and the church, intending by the latter every order of congregation and place of worship, though among the indoctrinating institutions one could and should include also the enlightened professions and the universities. But this subject is all too vast to be encompassed in its entirety. I must, therefore, limit my comments to religion and the church, and more to the church than to religion.

It is well known that to our great-grandparents, to those whose maturity was attained in the first decades of the last century, religion was a living reality and the church a vital institution. Apart from the more doctrinal subtleties about

which, I am persuaded, they bothered little and rarely, and except for the fanatical groups and sects, religion offered a broadly humanistic philosophy of fellowship, goodness, charity, justice, faith, and love.

Refurbished weekly in the Sabbath sermons, these values in life and living, these sanctioned goals of being, were the constants by which the individual could take stock of himself and of the world about. It mattered little if he took them not too much in earnest, or if he observed the letter and missed the spirit. At least they were there, constant, firm, and unaffected by violation and neglect. He could return to them, like the prodigal son to his father, in the days of his need.

The church, too, was ever present, truly the place of communion, not only for man and God, but also for man and man, for man and woman, for maid and lad. Within its walls, in the encompassments of its walks, in its adjacent cemetery where the dead of the past were a part of the living present, there was played the full gamut of life's song.

Few among us to-day can fully appreciate the rôle that the church and the synagogue played in the lives of our ancestors. The place of worship served for more than worship. It was where acquaintances were made and friendships were engendered. It was where romance insinuated its sparkling, bright spirit, to give temporal pertinence to the timeless verities. It was where courtships were often first inspired and ultimately sanctioned. In the place of worship each communicant could observe the sabbatical parade of the community and gain therefrom both the orientation derived from the *full* awareness of all about and also that most reassuring sense of being one of and among the many—that is, of belonging.

The place of worship, its minister, and its congregation served man's mundane as well as his spiritual needs. The church was an instrument of charity and of mercy. It succored the orphan and sustained the widow. It cheered the sick and consoled the bereft. It tempered the galling guilt no less than it goaded the slothful conscience. It reconciled the estranged and fostered justice. It gave refuge to the persecuted and aid to the abused. It was, in a word, a realm apart, wherein by his own efforts, and with the aid of the anointed, man could reconcile the temporal with the timeless, the mortal

with the immortal, the particular with the transcending, and thus achieve an effective relationship with both, the immortality antecedent to his earthly advent and to that beyond his demise. The church helped our ancestors to understand even when they did not know. It is tempting to affirm that we know where we do not understand.

Such was the church to our ancestors. But it plays no like rôle in our lives. Why? That's too large a question to treat in so brief a discourse. For the reasons are many, and some of them are very intricate. Besides, our obligation is to define the change, not to account for it. We need to recognize that the security and the insights that our forefathers gained through and from the church are not youthsafed us to-day.

And this, too, explains why so many intelligent, well-informed, and earnest men and women are interested in and turn to psychiatry. They hope to find in it the biologic counterpart of the "moral law." They seek to discover in psychiatry the rationale of those *values* which formerly were current as doctrinaire injunctions. They seek to discover the mortal mainspring of hope, love, and charity, and also of evil. They seek to be oriented as to the purpose and meaning of life and of life's experiences.

I am persuaded that more men and women are moved to inquire into psychiatry for these than for any other reasons. The phenomenal popularity of the books seeking to reconcile religion and psychiatry attests to the soundness of this persuasion. Man is a creature that lives by values, no less than by bread, and of late too many of his traditional values have been cast into doubt. In the cataclysmic upheavals of two world wars, goodness, love, charity, mercy, truth, humility, brotherliness, have been violated and mocked. There is current a highly organized, energetic, and cunningly resourceful propaganda which makes the homely virtues and the religious persuasions and faiths of our fathers appear like a compound of neurotic anxiety, infantile delusion, political-economic naiveté, and mean escapism. Many who are caught in the tension field of this propaganda seek refuge in doctrinaire bigotry; hence the resurgence of orthodoxy in morals and religion. But many more, I believe, are seeking to understand, and they find a source of orientation in psychiatry.

I cannot leave this theme without elaborating several other

related items. Science too often has been charged with having done violence to man's faith in God and religion. Psychiatry itself has been accused of gross materialism, of seeking to explain everything, thus leaving nothing to the divine mysteries. These charges are basically unwarranted. The primary aim and function of science—and within science we include psychiatry—is to add to man's knowledge concerning the universe and concerning himself *in* the universe. There is not and there cannot be a conflict between science and what is termed religion. There can only be an issue on the score of knowledge affirmed by science, and of that knowledge denied or contradicted.

It would be futile to deny that this order of conflict does involve both scientists and—may I call them—religionists. And it would be much less than candor did I not give it as my opinion that the fault lies most often with the religionists, who were loath to admit error and laggard in adapting their accounts and practices to conform to the sound data of science.

I underscore this point because I am persuaded that the loss in prestige and influence suffered by the institutions whose function it is to indoctrinate man in the habitudes and practices of altruism was in some measure due to their unreadiness to adjust their historical and doctrinal accounts to conform to the data of science. More understandable, however, was their laggardness—and I presume also their inability—to adapt themselves to the changed conditions and circumstances of our individual and communal lives.

The church was once the place where music was written and rendered, where the staged spectacle taught both the doctrine and the mystery, where the painter adorned the walls with his graphic portrayals of Old and New Testament scenes, where calligraphy was practiced and taught, where the young learned their alpha and beta, and the more advanced students the cumulative knowledge and wisdom of the ages. Here, in a word, the liberal arts were cradled and nurtured. The church was to its congregation, to the community, club, theater, opera, museum, library, school, welfare agency, nursing service, foundling house, "funeral parlor," and much, much more besides. In time, and mainly in recent years, these many and varying functions of the church have been taken over by lay groups and institutions. And the church lost out!

You must not conclude from this that I favor a return to the past, and that I advocate the abolition of all those professional lay groups who nowadays perform so skilfully the tasks and services previously rendered by the minister, the minister's wife, the men's committee, and so on. That is not my intention. It is rather this—that having perforce surrendered its many ancient functions, the church should have found new means wherewith to serve man and to tie him meaningfully to itself. In this respect it *has* been laggard, but there are encouraging signs of a mounting concern and activity in these directions, the best among them, the increasing number of clergymen, of all faiths, who are themselves becoming lay students of psychiatry.

In these last comments I may have sounded a little like a scold, but I disclaim any such intention. It is not my ambition to quarrel or to reprove. I mean only to illuminate. And if I sound critical, it is for the purpose of laying the basis for my concluding observation.

I have attempted to account for the prevailing widespread interest in psychiatry by the phenomenal disruptive changes which man and his world have suffered during the past hundred-and-fifty years. These changes have confused and bewildered men, and many among them are now seeking orientation and understanding in psychiatry. I have drawn attention to three particularly significant changes: the disappearance of the homestead, the degradation of woman's position in the family, and the loss in prestige and power of the institution that in times past effectively taught and fostered man's altruism.

In elaborating all this, it was never my intention to suggest that psychiatry does or can offer an effective substitute for any of the resources that have been lost. The psychiatrist, be he ever so learned, skilled, and gifted, can only hope to help correct the resultant faults, but cannot really make amends for the inadequacies of individual, familial, and communal life. The quiet, isolated, and permissive atmosphere of the psychiatrist's consultation room is most effective as a therapeutic arena, but it cannot amend the want of a happy childhood experienced in the bosom of a healthy family. The psychiatrist may help the patient to achieve an effective

reconciliation with a cruel or exacting reality, but it lies not in his power to temper the reality, past or present.

These observations are not intended to dwarf or to disparage the psychiatrist's competences for good, but rather to define the scope of that good. Psychiatry is not an *Ersatz* for religion, for love, for achievement in the requisites of manhood or of womanhood. It is not a consolation for the defeated, nor a crutch for the crippled. It is a disciplined science that explores and expounds the mechanisms and the dynamics of human motivation and behavior. It is a science that bridges biology and sociology. Because of its catholic scope, psychiatry is uniquely competent to illuminate many of the problems that beset and trouble every man.

And this, above all, accounts for Everyman's interest in psychiatry.

One final note. It is not my intention to pretend that psychiatry is the most erudite and sage of disciplines; that it will, like the Delphian Oracle, give answers to all questions and unravel all mysteries. There is so much, so very much beyond its *kēn*, and in that much, the sublimity and grandeur, no less than the transcendently tragic essences, of life. I do not want to claim too much for psychiatry. That were a folly too easily discerned. I mean only to define the reasons why the troubled and bewildered can and do find some measure of insight into the derivations and nature of the problems that beset them and us in contemporary society. In that insight they and we may perhaps learn how to resolve those problems and thus attain a more satisfactory and more effective existence.

DEVELOPMENTS IN RESEARCH ON DEMENTIA PRAECOX *

WILLIAM MALAMUD, M.D.

Director, Committee on Research in Dementia Praecox, The National Association for Mental Health

THIS paper is a brief report on the results of the investigations that have been in progress during the past year under the sponsorship of the Committee on Research in Dementia Praecox, of the National Association of Mental Health. Our current program includes seventeen projects, operating under the direction of investigators of high standing in leadership and ability, not only in the field of dementia praecox, but in scientific research in general. Funds for the program are provided by the Supreme Council, 33° Scottish Rite, Northern Masonic Jurisdiction.

Thanks to the generous action taken by the Supreme Council last year in increasing our allocation, it was possible to add four new projects to our program and to increase the funds granted to some of the investigations previously supported, whose significant contributions in the past and highly promising plans for the future warranted an extension and intensification of their research.

The seventeen projects cover a broad range of investigative procedures, including physiological, biochemical, endocrinological, psychological and sociological areas. At the same time, in keeping with our accepted policy, we have directed our efforts toward a coördination of activities and of focusing the research on the central core of our program—namely, a better understanding of the nature and causes of dementia praecox, with the ultimate goal of more successful treatment and prevention of this disease.

It seemed reasonable to start out with the presentation of a group of projects centered around an area that, in the last few years, has gained particular prominence in medical research in general—namely, study of the functions of the

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endocrine glands, particularly the adrenal cortex and the systems in the body that are related to it. The broad applicability of Cortisone and ACTH in the treatment of a large variety of diseases, and the remarkable effects it has had in the treatment of some chronic conditions that have hitherto been regarded as incurable, has created a great deal of interest among psychiatrists, particularly those working in the field of dementia praecox. This area of research has occupied the attention of some of our investigators for a number of years, but more recently the development of new methods of procedure and the discovery of new facts about the function of these glands have resulted in greater interest and more effective work.

Six of our projects have been directly concerned with this area of investigation. Some of these have been added to our group more recently, others have been in progress for some time.

Since the present phase of this subject is still in the early stages of development, it is of great importance to devise scientifically adequate methods of experimental procedure, and some of our workers have been successful in perfecting such new methods. Thus, the project that is being carried on at the University of Utah is particularly concerned with the perfection of reliable methods of measuring the substances secreted by these glands in the body fluids both of normal persons and of patients suffering from dementia praecox. Wide interest was attracted by the work of this group when it was reported at a recent national conference, and our investigators were able to report new findings in the pathology of this disease by the utilization of their method, bringing us nearer to an understanding of the influence that disturbances of these glands have on the development of this illness.

A similar contribution was made by the group sponsored by our committee at the University of Iowa, and another one that is being carried out at the Worcester Foundation for Experimental Biology.

The group at Worcester has been successful in producing these substances by the perfusion of adrenal glands, both in animal experiments and following operations on patients. In this way, they have been able to determine more exactly the pathological findings in diseases involving these glands and,

at the same time, with their animal experimentations, they have been able to develop new methods of producing these substances on a large scale, so as to make them available for treatment of conditions in which the secretion of these glands is below the normal amount necessary to preserve health. During this last year, they have also been engaged in activities jointly carried out by them and by workers in the University of Chicago in perfecting surgical procedures for the removal of the glands in cases in which the production of substances deleterious to human health was demonstrated.

At the present time, the use of Cortisone and ACTH has spread to a large variety of diseases, some of which, such as asthma and arthritis, are psychologically closely related to the disturbances that are found in dementia praecox. It is obvious that in conditions of this type, in which the use of these drugs has been proven to be highly successful, there is an opportunity to learn a great deal in regard to the possibility of furthering our knowledge of the nature of dementia praecox. A project of this type was started during the year at the Massachusetts Memorial Hospitals. It concentrated particularly on cases of asthma and other allergic conditions in which psychological disturbances closely related to that of dementia praecox have been observed. Here, again, new methods of procedure in the measurement of these substances, as well as in the study of the psychological and social stresses that contribute to the disease, have given us new concepts of the causes of dementia praecox and the possibility of developing methods that could be used both in treatment and in prevention of the disease.

A number of other systems in the body are very closely tied up with the function of the adrenal cortex, one of the most important of these being the adrenal medulla. There is ample evidence that these two organs are mutually interdependent and, at the same time, that they are both affected in a number of diseases, including that of dementia praecox. One of the projects we are sponsoring at the Boston Psychopathic Hospital has contributed a number of important discoveries in this field. It is of interest to note that here, too, relationships have been found to exist between the disturbances in both of these glands in dementia praecox and in asthma.

Thus it is evident that all of the projects discussed so far are

closely integrated, and in all of these investigations, studies of the biochemistry and physiology of these glands are proceeding in close relationship with studies of psychological and sociological stresses that are of importance in influencing the function of these glands, as well as the clinical manifestations of the disease.

As we proceed from this area into other aspects of our investigations, it is of interest to note, at this point, that another one of our recently started projects, at the Bradley Home in Providence, has concerned itself with the study of the function of these endocrine glands in children who are showing early signs of dementia praecox. It is obvious that any contributions we can make to the understanding of this disease in its incipiency will be of particular importance, both as regards basic research dealing with the fundamentals of the disease, and the possibilities of gaining control of such conditions at an early stage when the devastating effects of these disturbances may be arrested before they have caused too much damage and been rendered irreversible. This attempt to concentrate at least part of our efforts on the study of conditions of this type early in life brings up two other areas that have received our close attention.

The development of such disturbances in early childhood can be conceived as taking place on the basis of two factors: (1) a certain constitutional weakness which some children may have brought with them into the world and which makes them particularly vulnerable in their adjustment to life stresses; and (2) environmental stress situations that are apt to be especially damaging in cases of such vulnerable constitution.

The first of these two factors has been studied for a number of years by one of the foremost geneticists in this country, working at the New York Psychiatric Institute. During the last year an increase in our grant to this investigator enabled him to start on an investigation of these constitutional factors in young children. The group of investigators working with him have been able to organize a systematic program in the state of New York through coöperation with a number of agencies working with adjustment problems in children. For a number of years this scientist and his associates have been supported by our grants in the study of genetics in adults. This background renders him especially capable of attacking

the problem at its very foundation in the study of young children.

On the other side of this picture are the investigations that are being carried on for the purpose of determining the nature of the psychological and social stresses that may interact with the constitutional factors in producing the disease. Two projects that we have been supporting for some time are especially concentrating their efforts on this phase of the work. A great deal of progress has been made by the group working at the University of Toronto, especially through the connections this group has been able to establish with the large community resources in that city. They have been able to demonstrate the effects of damaging experiences in early childhood, such as stresses exerted by unfortunate family and home situations, or those in the school and in the neighborhood, which, in the case of a great many children, particularly those who are more vulnerable, leads to their withdrawal from active adjustment, creating a situation that may lead to the development of *dementia praecox*.

Their program includes not only the purely scientific attempt to discover the factors that contribute to disease, but also experimental investigations of possible means of influencing these conditions in such a way as to prevent further spread of the process into a full-blown mental disease later in life.

A closely related investigation is the one carried on at the Children's Center in Roxbury, where a simultaneous study is being made of children who show early signs of the disease and normally developing children in the "well-baby" clinics. Here, again, it has been possible, during the course of the investigation, to gain a better understanding of the psychological and social factors that tend to produce the disease by comparing the life histories of these children with those of children in whom such deleterious effects are not present. At the same time the investigators are working toward the development of a sound program for treating children who have begun to show signs of the disease, so as to arrest its pernicious progress and prevent it from developing into a chronic ailment. A number of these children have actually been able to return to a better adjustment in the community at the conclusion of the treatment.

In order to grasp the fundamental facts in regard to the

structure and function of the organism that may be the groundwork of the development of this disease, it is essential to continue basic research into the anatomy, physiology, and biochemistry of living organisms. This has been accomplished in our program by several of our investigators. A new project that has been started at the Johns Hopkins University is primarily concerned with the study of certain parts of the brain whose removal or impairment can lead to the development in animals of behavior disturbances that are very closely related to the types of disturbance the physician observes in sick human beings. Outbursts of anger, hostility, panic, in animals in which certain specific parts of the brain have been damaged or removed, help us to gain greater insight into what may be taking place in some of our patients and, at the same time, to understand the nature of the process that takes place in certain surgical procedures that are now being used in the alleviation of a number of mental diseases, including dementia praecox.

Closely related to this are the studies carried on by several investigators in the biochemistry and physiology of the nervous system. A project that we have been sponsoring for some time at the Washington University in St. Louis has resulted in important contributions to the understanding of the electrophysiology of the nervous system and the manner in which impulses are developed and conducted in the nervous system of animals as well as human beings. It has also demonstrated the difference in the nature of these processes in the normally functioning organism and the organism that is pathologically affected.

The question of the utilization of certain chemical substances in the normal and diseased metabolism of the nervous system has been further followed by the projects being carried out at the University of Pennsylvania and the Johns Hopkins Physiological Laboratory. These projects are concerned particularly with the chemistry and physiology of oxygen metabolism, and the effects of deprivation of oxygen or a superabundance of it on the behavior and general function of the human being. One of our projects at the University of California has continued with the study of the effect of electric convulsions on animals, the manner in which they affect the whole life of the organism, the damage they may cause, and

the therapeutic effects they may have in cases of disturbed behavior. This is of especial importance in view of the widespread use of such a procedure in the treatment of a high proportion of dementia-praecox patients.

Another project, at Columbia University, is concerned with the importance of certain chemical substances known as enzymes and the influence they exert on the function of the central nervous system and thereby on human behavior and adjustment.

Finally, our project at the Henry Phipps Clinic in Baltimore has been carrying on a series of broadly conceived investigations into the process of psychiatric treatment of patients suffering from dementia praecox. The nature of the particular methods used, the manner in which different workers use these methods, and the effects of both on different types of reaction pattern in the disease, are generally emerging as important factors in the ultimate success of the treatment of this disease.

Notwithstanding the fact that our general policy, at the present time, is to concentrate our efforts in an integrated fashion on an attack on the disease, dementia praecox, we are still on the alert in making use of scientific by-products as they cross our path. Discoveries that are made in the search for a better understanding of dementia praecox, no matter how much we focus on this particular area, cannot help but bring also better understanding of other diseases. Our studies of asthma, in addition to furthering our knowledge of dementia praecox, will obviously help in the understanding of asthma and allied conditions. The development of methods for mass production of the substances secreted by the endocrine glands will, of course, be of great use in other diseases that are influenced by disturbances in these glands. This is also true of the results of our studies of children, since they have already been found to be of as much importance in bringing about a better understanding of problems in child behavior in general as they have been in furthering our insight into the nature of dementia praecox.

The significant results achieved by the investigations supported by the Supreme Council of the 33° Scottish Rite Masons have led to a broadening of the field both by introducing new methods of research and by attracting new scientists into this field. In a recent survey conducted in the United States and

Canada I have found a number of well-organized plans for research, in institutions most adequately equipped to undertake the investigations, directed by highly capable and enthusiastic workers.

It is encouraging to find that in most cases the grants made by our foundation have stimulated the interest of others and that our investigators have been able to broaden their research activities through funds both from federal and from private sources. It is hoped that the Supreme Council will continue to function in its rôle of leadership in this field, and that, by broadening its own scope of attack on this important problem, it will encourage other benevolent organizations to serve humanity in its fight against disease.



TRAINING IN THE PSYCHIATRIC DISCIPLINES*

GEORGE S. STEVENSON, M.D.

Medical Director, The National Association for Mental Health

THE National Association for Mental Health is a citizens' voluntary association. As citizens, we are appropriately concerned that the mentally ill shall have good service from the psychiatric disciplines. We should, therefore, do everything we can to strengthen these disciplines by giving them good working conditions, adequate preparation for the performance of their duties, and a better and greater body of scientific knowledge with which to work. This means better hospitals, better training, and more research.

The psychiatric disciplines include all those who deal directly with the patient as such—the attendant, psychiatric aide, or psychiatric technician, who is on hand to serve the patient on the ward day in and day out; the nurse, who in state mental hospitals serves in an administrative and supervisory function over the ward service and gives little, if any, direct bedside service; the psychiatrist, who is responsible for all that happens to the patient in the hospital, including his treatment, whether rendered directly or through the nurse or aide. Then there are the collateral functionaries who operate through the doctor, the nurse, and the aide. These include social workers, hydrotherapists, occupational therapists, psychologists, and other special therapists. With the separation of the patient from the hospital, the team shifts from doctor-nurse-aide to doctor and social worker.

The time was when all of these psychiatric disciplines secured their professional training in a rather hit-or-miss manner. They were engaged for and primarily preoccupied with service to the patients, and training was left pretty much to the trainee to work out for himself. There was too little supervision and too little planned education. This "training" was sometimes sold to the trainee in attractive wrappings.

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without too much substance inside. It was essentially an apprenticeship that tended to disguise the use of the trainee as cheap labor. Until recently even formal approval of a hospital for residency meant little that was positive; it meant that merely the very poor hospital was rejected.

Some twenty-four years ago, The National Committee for Mental Hygiene, now one of the components of The National Association for Mental Health, took steps to improve this situation. It collaborated with the American Psychiatric Association in forming a committee under whose auspices an attempt was made to raise the level of psychiatric education in medical schools.

Under the influence of this program, important advances have been made. I recall being asked in 1926 to lecture on psychiatry to the students in one medical school, it being indicated that this was all the psychiatry they would get. I was allowed ten minutes. In most medical schools the number of hours devoted to psychiatry in the curriculum have been increased, but, more important, the design of psychiatric education has been reconsidered and now tends to provide the psychiatry that will be needed by every doctor, instead of attempting to produce a specialist. The training of specialists has come to be thought of as a postgraduate task, carried on mainly through well-designed experience in a mental hospital, called a residency.

In 1939, The National Committee for Mental Hygiene, took additional steps to improve the residency, keeping within the bounds of legitimate citizen functioning. It followed three postulates: (1) that the hospital should design its training program and spell it out on paper; (2) that the training should be a part of the compensation of the trainee and constitute a commitment to him, so that if the hospital fails to deliver on its promise, the trainee can appropriately consider himself cheated; and (3) that the trainee would be informed as to what to expect in the way of training, so that he can tell whether the commitment has been honored.

In coöperation with a number of leading hospitals, a schedule was developed to be used by hospitals in setting down on paper what they offered residents. It was then sent to all mental hospitals to be filled in. The training in some 125 hospitals was thus compiled in a book, which was made avail-

able to all senior medical students and internes who might be considering the field of psychiatry. The Committee on Psychiatric Education of the American Psychiatric Association formulated a statement for this compilation to serve as a guide to the applicant in choosing a residency.

Since that time the quality of our best residencies has greatly improved and they have increased in number. This was in no small measure due to the serious planning of psychiatric education during the war and the opportunities offered by the Veterans Administration through excellent leadership in Washington and through collaboration with medical centers. To-day much more is expected of a residency than ever before and the inspection of hospitals for approval is becoming more stringent. Recently a number of hospitals have lost this approval. These are hospitals which are not aware that the "old order changeth giving place to the new."

New patterns of psychiatric residency are now appearing. Most important among these is the tendency to get away from the institutional concept of a residency in which the whole training is given in one mental hospital, and, instead, to think of it as a varied training in a number of institutions and outpatient services as preparation for the full range of duties of a psychiatrist. Massachusetts has developed an especially interesting training program along these lines, and The National Association for Mental Health is fortunate in having on its board a man who has played a large part in this—Dr. William Malamud.

In another way The National Association for Mental Health has been very much involved in psychiatric education. As far back as 1923, one of its member associations, The National Committee for Mental Hygiene, offered fellowships in child psychiatry. This confronted it with a responsibility that is not entirely appropriate for a citizens organization. It was required to make decisions as to what should be the prerequisites for training, what constitutes a good training program, and what centers should be approved for training. It carried out this inappropriate function merely because no other organization was prepared to take it on and so it might be said that it acted by default. But several years ago it moved to correct this situation by encouraging certain outstanding clinics to join together in a professional association that would

assume the responsibility for establishing prerequisites for training, the content of training, and the approval of training centers. Early this year The National Association for Mental Health was able to pass on to this American Association of Psychiatric Clinics for Children the full responsibility for these three functions.

About two years ago The National Association for Mental Health also relinquished its long function of providing psychiatric fellowships, made possible by grants from the Commonwealth Fund, as the National Institute of Mental Health, under the National Mental Health Act, had shown that it could go far beyond a voluntary organization in making such provision.

Throughout our experience with fellowships, the number of applicants has always been meager. Now, due to the improvement both in basic medical and in basic psychiatric education, the number and quality have improved. The interest of young physicians in psychiatry has materially increased. It was the need for this more basic preparation that impelled us twenty years ago to focus on the medical school.

Two years ago the American Psychiatric Association took another step forward in holding a conference, along with the deans of medical schools, to consider psychiatric education in medical schools, and in this I was glad to be a participant. This conference was financed by the National Institute of Mental Health under the National Mental Health Act of 1946, which we had a large part in bringing about.

Recently, a second conference on psychiatric education was held, this time focused on the preparation of career psychiatrists—that is, specialists. In this also I was privileged to participate. Through these conferences advances have been reached relative to psychiatric education. These The National Association for Mental Health is determined to promulgate in every way possible. That is its rôle in the team. It will bring them, properly interpreted, to the attention of state associations for mental health and to related professions whose training parallels or dovetails with that of psychiatry. It will formulate a list of experts to whom those who are planning programs of psychiatric education will be referred.

The National Association for Mental Health is concerned that every hospital should be a training center. The Veterans

Administration has shown how a well-conceived training program tied in with a medical center raises the quality of service rendered by the hospital and keeps it on its toes scientifically. The National Association for Mental Health has formally concluded that "any hospital is a better hospital when it becomes a training center and that it is a responsibility of national, state, and local mental health groups to promote training programs where they do not exist and where they could be advantageously introduced; that The National Association for Mental Health looks to the Conference on Psychiatric Education as the responsible body to formulate principles and standards of psychiatric education and that it recommends the study of the report of that conference as soon as it is available." It has, in fact, spelled this out as one of the specific points in its authorized program.

But a training hospital should offer training not only for psychiatrists, but for all psychiatric disciplines. The nursing personnel of state hospitals is to-day but a small fraction of the number called for in the standards of the American Psychiatric Association. This is a matter of grave concern to us, and our concern is expressed in large part by our having a member of our staff on three important committees within the nursing field—the Committee on Improvement of Nursing Services, the Mental Hygiene Committee of the National Organization for Public Health Nursing, and the Committee on Psychiatric Nursing of the National League of Nursing Education. With the merger of the nursing organizations last spring, these last two committees were combined. One of them has to do with the development of personnel to serve as mental-health consultants in the field of public-health nursing, and since it began its work, a number of university training courses for such personnel have been established. The second is concerned with the nursing of psychiatric patients primarily in our mental hospitals.

As in the field of medicine, a distinction is being made between the full training of a psychiatric nurse and the affiliate course of some three months or so in which a student nurse gets the psychiatric component of her training. This is basic nursing education and is not intended to produce psychiatric nurses. The affiliation, however, is too often inadequately designed and apt to result in the use of the student as cheap

labor. The nursing field is very conscious of this tendency and is dealing with it vigorously.

Preparation for the specialty of psychiatric nursing has advanced primarily during the past ten years under the leadership of the American Psychiatric Association, which is now accrediting training centers for this specialty.

In the nursing field as a whole, the perspective of leaders has greatly increased, so that they are taking into account all categories of nursing personnel and not just the graduate nurse. They have already gone on record, for example, as approving the principle that the trained practical nurse, where qualified, should be helped to move on into the nursing field with a minimum loss through duplication of her original training.

The psychiatric aide, of course, has been a major interest of The National Association for Mental Health for some years. Opinions differ as to whether the psychiatric aide is one classification of nursing personnel or not, but there is a generally accepted axiom that the quality of service rendered by any institution is largely determined by the quality of the personnel who function most closely to the individual served. The citations offered for the Psychiatric Aide of the Year Award reflect in the good aide a personal quality, at present not clearly defined, which not only helps him to understand patients whom sometimes the doctor and nurse do not understand, but to do things for the patient that are especially helpful. These are qualities that are secured rather by selection than by training, but there appears to be some degree of non-verbal transfer of these qualities from the experienced to the inexperienced trainee who works under him.

In 1944, the interest of The National Committee for Mental Hygiene in the psychiatric aide was greatly increased, and through its interest training programs for psychiatric aides have been initiated and improved in quality. Through the personal consultation given by Mr. Paul Harris, of our staff, and through the magazine, *The Psychiatric Aide*, many advances have been made. These came to a head recently in three conferences in which the American Psychiatric Association and The National Association for Mental Health joined hands in bringing together some twenty-five persons to exchange viewpoints and arrive at certain understandings,

if not agreements, on steps to be taken in improving the training and the general lot of the psychiatric aide. The first of these was held at the Peoria (Illinois) State Hospital in October, 1951; the second at the Manteno (Illinois) State Hospital, January, 1952; and the third at the Larue D. Carter Memorial Hospital, Indianapolis, last October.

There are some who consider the psychiatric aide merely as an expedient to cover the shortage of psychiatric nurses. Most of us cannot agree with that viewpoint, and have recognized that the psychiatric aide existed prior to psychiatric nursing, and that even if psychiatric nurses were available in full supply, the psychiatric aide would still be the appropriate functionary for the position that he fills. In any case, the qualified psychiatric aide has legitimate aspirations which he should be helped in realizing:

1. He wants to be respected as a member of a team, doing a serious job for a patient.
2. He wants to be technically qualified to perform the functions with which he is confronted in service to the patient.
3. He wants to have an opportunity to advance professionally, perhaps similar to the opportunity that has been afforded the practical nurse. The American Psychiatric Association, recognizing the fact that the ultimate responsibility for the psychiatric patient rests with his psychiatrist, is taking this seriously, and I have no question that important steps are in the offing.

There are three other professions in the psychiatric disciplines which I will not attempt to deal with at this time. They should be of concern to us, but we have not had the resources with which to express our concern. I mentioned above that there are collateral services given by psychologists, occupational and recreational therapists, and hydrotherapists, and so on.

There is also the psychiatric social worker. To this profession we have given more attention in the past than at present. In fact, this association played an active part in the establishment of the first training for this profession and Dr. Marion E. Kenworthy, of our board, has been identified with it during the full span of its growth. Both she and I have served as chairman of the American Psychiatric Association Committee on Psychiatric Social Work, which has worked

closely with the American Association of Psychiatric Social Workers and spelled out a number of advances in training and in the functioning of the psychiatric social worker.

Within the field of social work, there is currently some tendency to neglect the distinction between psychiatric social work and the psychological elements that enter into all social work. This is the counterpart of a distinction that exists also in nursing and in medicine. There is danger that the distinctive function of the psychiatric social worker may become lost in the confusion and it is a responsibility of this association, along with psychiatric-social-work leaders, to see that this does not take place. Psychiatric social workers are present in our state hospitals to-day in just about the same inadequate ratio as nurses. If the isolation of our state hospitals, as many of us believe, is one of their more serious handicaps, then the development of the social-work function is essential to the removal of that handicap.

In the early days psychiatric social work was focused on the follow-up function of our state hospitals—an essentially outpatient activity. Then it moved even further from the hospital into the child-guidance clinic. Now, encouraged by the attractive opportunities opened by the war and the Veterans Administration, service to the mentally ill is taking on new meaning for social work.

A leader in our field has pointed out that a hospital building never cured a patient—that is done by the personnel. Qualified personnel is our goal.

COMMON FACTORS IN BUILDING UNDERSTANDING AND BROADENING THE BASE OF CITIZEN PARTICIPATION IN HEALTH AND WELFARE ORGANIZATIONS*

SALLIE BRIGHT

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THE first factor in a successful attempt to build a citizens' movement is an honest desire to share the job with the public. I am not sure that all boards and staffs have that desire. Sometimes I seem to detect a desire, rather, to get a great, big foundation grant and go on with the job without bothering with the public.

The second factor, it seems to me, is that an organization must be very clear about what it is, the need it proposes to meet, and how it proposes to meet it. This does not mean that citizens are drawn into a movement to do as they are told. As more citizens are involved in a movement, they begin to add ideas and influence. But no citizen is moved to join—or, in any event, to remain with—a movement whose purpose is not clear, the need for which is not clear, or whose program emphases are confused. As a citizen, for example, I would want to know whether the mental-health association with which I was being asked to serve was primarily working toward better facilities for people already mentally ill, or toward the prevention of mental illness, or toward both, and in what proportion.

Closely allied to this factor of clear purpose is a third factor that is common to all health and welfare organizations as they attempt to build public understanding and draw participants to them. This is the factor of image. Not being part of the mental-health movement directly, I may be getting myself into hot water by using words like "image," but in public-relations terms, "image" means the picture of an organization that is presented to the public.

*Presented at the Second Annual Meeting of The National Association for Mental Health, New York, November 18, 1952.

You are familiar with some of the image problems—and advantages—that certain health and welfare organizations struggle with or enjoy. Hospitals, whereas they are centers for the blessed alleviation of pain, struggle against a public image of themselves as authoritarian, cold, fearsome, anti-septic-smelling, expensive. Family agencies are working hard to dispel the image of charity and relief. The Salvation Army enjoys an image of a band of self-sacrificing, charitable, godly samaritans. It is not without significance that a Salvation Army lass can enter the lowest dive without fear of being molested.

An image is an impression—and an impression is built by a lot of different things. But the first step in image-building is to decide what image you are trying to present. In your case, the image of the mental-health association may be closely linked with the image of the patient that the public has—and even the image of the psychiatrist. An agency dealing with crippled children has a certain flavor that an agency dealing with feeble-minded children does not have. An agency that presents itself to the public as a resource for the mentally ill has a different image than an agency for preventing mental illness. A hospital, which cures illness, has a different image from that of a health department, which prevents illness. The image you wish to present is for you to decide. But it must be a clear image—clear to you and capable of being made clear to the public.

And this opens up a fourth factor. Even if you succeed in making your purpose clear, and the image of your agency that you present is a truthful one, there is the question of whether this purpose and this image interest the public and can easily be accepted by it. This question is common to all organizations, but the degree of potentiality for immediate public acceptance is not common.

The Boy Scouts is a movement with great potentiality for public interest and acceptance. Little boys are interesting; the kinds of project Boy Scouts indulge in—nature trips, doing good deeds, getting out the vote, serving in flood and fire and storm—are interesting, understandable, and approved of by the public. Not only that, Boy Scouts are visible—because they are in uniform. But there are other organizations whose programs have great problems of public acceptance—Planned

Parenthood, for example, or agencies for unmarried mothers.

This does not mean that we should attempt to build only movements that are calculated to win immediate public interest and acceptance. There would be no progress if that were true. It does mean, however, that the agency that deals with a little known subject, or one with frightening aspects, or one that collides with accepted codes or beliefs in the public, has a harder time.

This only means facing the facts, realizing what these obstacles to public acceptance and interest are, analyzing the agency story as to what parts are most likely to be interesting and acceptable, and working hard to get the tougher parts to the public in a way that will gradually break down public resistance and build public interest.

And this brings us to a fifth factor—evaluation of your public-relations position. I am not talking here necessarily of expensive public-opinion polls, although well-conducted polls are valuable. I'm talking about knowing, by whatever means you choose to find out, what your public-relations problem really is. How many people are frightened of mental illness? How frightened are they? How much disgrace do people feel in seeking even preventive treatment? What is your association's relationship with other organizations who are, in their separate ways, doing a job in mental health? What has been your experience with recruiting volunteers? Why? Are you able to recruit staff? Why not? We can't take time here to discuss all the other questions you would want to ask yourselves—and answer—or the ways to answer them, although from the few I've named you can see that some of the answers are in your own records, and need only to be frankly faced.

But we must make this one point: You must know how you stand with the public *now*, before you can plan intelligently for future relations. Unless you know what your present strengths and weaknesses are—and why—you may waste time fighting windmills, beating down fears that don't exist, and fail to deal with other attitudes that you don't realize do exist.

Now, armed with clarity of purpose, clear definition of the image you want to present to the public, an honest analysis of your story in terms of potential public interest and acceptance,

and as accurate an evaluation as you can make of what present feelings are toward you and your subject, let's look at another and sixth common factor. What you want people to *do* about your program must be made clear. Like most volunteer agencies, you will want them to give money, to back legislation, to volunteer their services.

It's remarkable, the number of agencies that fail to get public support because they are not clear in their request for it. I have received letters asking me to "get behind slum clearance." Is there a bill they want me to vote for? Do they want me to help tear down some buildings? Form a committee? Then there is the deluge of material these days dealing with "preserving our freedoms." What do they want me to *do* about that? What do you want people to *do*? What *can* they *do*?

Let's consider this matter of participation for a moment. No movement can handle all its potentially interested citizens as volunteers. But people can participate, and very satisfactorily, by giving money and voting for legislation.

Now, this matter of giving money brings up the whole question of membership. Most mental-health associations operate on the membership plan. What does membership mean? What do you want the members to *do*? If you are honest, you want their money and their moral support. You don't want them all to volunteer for work in a clinic. They aren't even all fitted for volunteer work.

And that's all right. There's a difference between being a member of a mental-health association and being a member of some other organization. Members of the Y.W. and the Y.M. can swim in the pool, eat in the cafeteria, even live in the organization's building. Why try to stack up membership in a mental-hygiene association in the same way when it isn't the same thing? I worked with a mental-hygiene association not so long ago on a membership folder, and the "advantages" of membership they listed were using the library, attending lectures (which non-members could also attend), and getting the monthly bulletin. These are pretty feeble, as "membership advantages."

It is valuable, however, to join a movement in which you believe. There's a real kick in that, if you know that your

money is going toward making it possible for some one—not you—to conduct an active program. That is *doing* something for mental health.

But what about the people from whom you do want more active participation? This brings up a seventh common factor—the need for real jobs for those people. Not made work, not unimportant work. And this brings up something so fundamental that even though it is a part of this general subject of volunteers, I'm going to call it a separate factor—our eighth factor. It is closely allied to our first factor.

This is the honest desire on the part of the *professional* to share the job with the *non-professional*, with trust, with respect, without threat or fear. This, and only this, will make possible the clear and satisfying division of labor, and mutual respect. Only with this can we hold the volunteers we recruit, for mental health or any other movement.

On the practical side is a ninth common factor—the training and continuous supervision of volunteers, not only that they may be good volunteers, but that they may be what all agencies want them to be—active interpreters. Orientation courses are not enough, any more than initial training with no continuous supervision or in-service training is enough for staff. Orientation courses are necessarily brief and general, whereas real learning comes later, as the job is being performed. It seems to me that this would be particularly true in a subject like mental health. Your hospital volunteer may have a variety of reactions to adjust to. She needs continuous help.

Why? To have a satisfying experience as a volunteer, to do her job well, and to interpret the program correctly to her friends and associates, to help with that image building. This is the strongest possible way to build public understanding. We call it "word of mouth" interpretation.

And don't fool yourself. A faithful, friendly volunteer isn't necessarily a good interpreter. She may not know as much as you think.

This applies also to the board, who may not know as much as you think: which brings us to a tenth common factor—the need for board education. This involves us in an examination of the quality of our board meetings, the quality, or even existence, of board-member manuals, a frank consideration of the

opportunities we give our board members to learn so that they may go out to teach.

Which leads us to an eleventh point: volunteers and board members as sounding boards for community attitudes. When was the last time you asked the board, your volunteers, your committees, what questions they were being asked out in the public? What things do they find people don't understand? How can these questions be answered? This kind of discussion with your volunteers serves both as a measure of public opinion and as an opportunity for public-relations training of your personnel. This brings us to a twelfth factor in building a citizen's movement—the skill of the staff in interpretation. The staff must have the opportunity to discuss public-relations questions and to learn how to phrase answers. Psychologists, psychiatrists, and psychiatric social workers don't just naturally do a good interpretation job. They need the opportunity to learn, too.

Out of all these factors (and I've had to omit a lot of others) comes a thirteenth and last—and very humdrum one. In every agency, although the whole staff and all the volunteers are involved, some one must be assigned to the job of coördinating the efforts to build public understanding. There will be tools to manufacture—booklets, folders, exhibits, annual reports. There will be meetings to arrange, movies to be shown. The training job for board, volunteers, and staff must be a conscious program. It won't do itself. Some of you will have public-relations staff, but most health and welfare agencies are without special staff for this purpose. When this is so, there is urgent need for a public-relations committee to serve as a substitute staff, with specific staff members assigned to work with it. Some one must be responsible. This is *planning*—without which nothing gets done.

All these generalities I have listed are true—but many are honored in the breach, to the detriment of health and welfare. As a young movement, you can avoid the mistakes of others, if you will keep these common factors in mind as you go forth to build your citizens' movement.

EDUCATION OF THE PUBLIC—A FUNCTION OF THE PUBLIC PSYCHIATRIC HOSPITAL

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MANY public psychiatric hospitals have been so busy grappling with the problem of too many patients in too little space that they have had little time for education of the public. Yet if the public psychiatric hospital is to solve its own problems of shortages, it can do so only through clear statements of need made to the general public, who pay the bills for 97 per cent¹ of all hospitalized cases.

The psychiatric hospital, operated by the federal, state, or local government, was created to fill a need that could be met by only a very few individuals. As a public service, the government-operated mental hospital not only protects the community from the violence of "depraved and maddened persons," but for the average citizen—the 97 per cent of the public who must use the public psychiatric hospital if they need mental-hospital care—it provides diagnostic services; intensive treatment for acute mental illnesses; mental and surgical treatment and therapy for tuberculosis for mental patients who need such services; and nursing care for the aging and continued treatment for the chronically ill mental patient. The public expects its government-operated hospitals to practice good medicine and to provide dignified, comfortable care. The average citizen feels that taxes are high. Funds collected by taxation should be adequate, he believes, to meet the needs of the mental hospital operated by government.

When, from time to time, articles calling attention to shocking conditions in some local mental hospital appear in the public press, in popular magazines, or, in books like Albert Deutsch's *Shame of the States*,² the average citizen reacts with disgust and bitterness toward the authorities who allowed such conditions to exist.

¹See "Hospital Service in the United States. The 1951 Census of Hospitals," *Journal of the American Medical Association*, Hospital Number, May 10, 1952, with supplement.

²New York: Harcourt, Brace, and Company, 1948.

Just how does the public discover what the needs of the mental hospital are if they are not made known? The superintendent may feel that he has done his part when he has placed his recommendation before the legislature—the elected representatives of the people—and when he has set forth his needs in an annual report that is usually a “dry-as-dust” document glanced at only by other mental-hospital superintendents, and read by no one.

Most state hospitals give good custodial care, but too often medical standards are not high enough. Overcrowding is often extreme. There are not enough nurses and psychiatric aides to give proper care. Buildings may be fire traps or so obsolete that modern facilities for progressive medicine are lacking. There may not be enough doctors in the state hospital to make it possible for necessary therapy to be given. If the public is aware of these shortcomings, it can put pressure upon legislators to correct the faults. Informing the public on such matters is worth the time it takes away from patient care.

There is much more, however, to a public-education program than just increasing appropriations to relieve the troubled conditions under which many state and county mental hospitals work. There is hope that some mental disorders may be prevented. Early treatment of the emotional and psychological problems of children, of delinquents, of families, and of adults, even of the aged, may prevent the need of hospitalization later.

Don't expect, however, that a public-education program of this kind will decrease the need for hospital beds for the mentally ill. It will not. As public confidence in the work of mental hospitals increases, more people will be willing to use them. But the need for new construction to add more beds may be offset by a more rapid turnover of the beds now available. Early treatment and modern intensive therapy in most instances result in a shorter stay in the hospital.¹

EDUCATION FOR BETTER MENTAL HEALTH

The public-education program can have two major objectives—early recognition of mental illnesses and their prevention.

¹ See “The Need for Uniform Discharge Statistics in Public Psychiatric Hospitals,” by Walter E. Barton, Harvey J. Thompkins, and Aaron B. Nadel. *American Journal of Psychiatry*, Vol. 106, pp. 429-39, December, 1949.

1. Early Recognition of Mental Illness and Prompt Treatment.—Facilities for dealing with mental illness and programs of recognition are important at every age. During the school years, counseling services may bring to attention for study and help the child who is retarded, the child with reading difficulties, or the solitary child. Student-health programs and vocational counseling centers are examples of methods of reaching older school children. Child and youth guidance clinics provide help with the diagnosis and treatment of emotional and psychological disorders that are serious enough to require specialists' care. The courts look for psychiatric consultations in dealing both with juvenile offenders and with adult recidivists. Pastoral counseling centers and an informed clergy can deal with many problems of family relationship, marriage, and so on. Outpatient departments in general hospitals and in the community for adults with mental disturbances are other examples of agencies that carry out an important part in the prevention program.

Furthermore, there needs to be a reservoir of people trained in the recognition of emotional and psychological problems who can apply the principles of mental hygiene to the minor ailments, and who can refer those with serious mental disorders to the appropriate agency for help or therapy. Such a reservoir might include teachers, clergy, doctors in general practice, public-health nurses, social workers, probation officers, lawyers, and judges.

2. Prevention.—Whom shall the educational program aim to reach?

Parents and families. “Because the early life experiences of the child are so important for healthy development of his personality, certain effective mental-health programs may well begin with parents, educators, and all those responsible for the training of the child.”¹

Children in school and their teachers.

Health and welfare workers in the community, such as physicians, public-health nurses, social workers, probation officers, and leaders of youth organizations.

¹ See *The Promotion of Mental Health in the Primary and Secondary Schools*. Group for the Advancement of Psychiatry Report No. 18, January, 1951. Obtainable for 10 cents from G. A. P., 3617 West Sixth Avenue, Topeka, Kansas.

Pastors and churches, for people in trouble turn to their spiritual leaders for guidance.

Industrial leaders and union leaders, who best know the pressures upon people that arise at work.

Opinion-forming community groups, such as churches, women's clubs, Parent-Teachers' Associations, and service clubs.

Content of an Educational Program.—What shall be the content of an educational-program in mental hygiene? Limitations of space will prevent any discussion here of details, but the content would be directed toward the groups mentioned above—parents and families;¹ teachers;² health and welfare workers;³ nurses;⁴ probation officers;⁵ chaplains,⁶ and industrial and union leaders.⁷

¹ For helpful material in this field, see *Fathers Are Parents, Too*, by O. Spurgeon English and Constance J. Foster (New York: G. P. Putnam's Sons, 1951); *The Happy Family*, by John Levy and Ruth Monroe (New York: Alfred A. Knopf, 1938); *As the Twig is Bent*, by Leslie B. Hohman (New York: The Macmillan Company, 1941); *The Challenge of Adolescence*, by Ira S. Wile (New York: Greenberg Publisher, 1939); and *You and Psychiatry*, by William C. Menninger and Munro Leaf (New York: Charles Scribner's Sons, 1949).

² See *Human Relations in the Classroom* (obtainable from the Delaware State Society for Mental Hygiene, 1400 Franklin Avenue, Wilmington, Delaware); *The Promotion of Mental Health in the Primary and Secondary Schools* (previously cited in footnote on page 38); *A Pound of Prevention. How Teachers Can Meet the Emotional Needs of Young Children*, by James L. Hymes, Jr. (obtainable for 25¢ from the New York State Committee on Mental Hygiene, 105 East 22nd Street, New York 10, N. Y.); *Report of Conference on Mental Health in Schools and Teacher Education Institutions* (Federal Security Agency, Office of Education, Public Health Service, Washington, D. C., 1949); and *Personal and Social Adjustment*, by Wayland F. Vaughn (New York: The Odyssey Press, 1952).

³ See *Psychotherapy in Medical Practice*, by Maurice Levine (New York: The Macmillan Company, 1942); *Psychosomatic Medicine*, by Edward Weiss and O. Spurgeon English (Philadelphia: W. B. Saunders Company, 1943); and *The Second Forty Years*, by Edward J. Stieglitz (Philadelphia: J. B. Lippincott Company, 1946).

⁴ See *Nurse-Patient Relationships in Psychiatry*, by Helena W. Render (New York: McGraw-Hill Book Company, 1947); and *The Nature and Direction of Psychiatric Nursing*, by Theresa G. Muller (Philadelphia: J. B. Lippincott Company, 1950).

⁵ See *The Doctor and the Difficult Child*, by William Moodie (New York: The Commonwealth Fund, 1940); and *Crime and the Mind*, by Walter Bromberg (Philadelphia: J. B. Lippincott Company, 1948).

⁶ See *Religion in Illness and Health*, by Carroll A. Wise (New York: Harper and Brothers, 1942); and *Religion and Health*, by Seward Hiltner (New York: The Macmillan Company, 1943).

⁷ See *The Application of Psychiatry to Industry* (obtainable from the Group for the Advance of Psychiatry, 3617 W. Sixth Avenue, Topeka, Kansas).

The psychiatrist who is responsible for developing the content of an educational program will be aided by the humble recognition that most of these people are already expert in their chosen fields, with a vast amount of practical and useful information which they daily employ. The sharing of information—case-centered about a problem with which they need help—is often a better frame of reference for learning than a carefully prepared lecture. When special needs arise, one of the easiest reference sources to content the psychiatrist can use is the handy volume by Karl A. Menninger, *A Guide to Psychiatric Books.*¹

How can the state hospital contribute to a public-education program in the field of mental health?

1. *By providing good treatment.* A satisfied patient may be helpful in providing a measure of public education. If admission care is thorough, if careful study is made of each patient, if correct diagnoses are made, if prompt application is made of the appropriate treatment whenever it is needed, if the attitude of all employees in the institution is conducive to recovery, if every effort is made to preserve individual rights, and if there is maintenance of the patients' self-esteem, with patient government, patient clubs, and doing for others, with the healing efforts of work—then the patient who leaves the institution and returns to his home will be one who will discuss his illness with others and help others to understand that mental illness may be a recoverable disorder. There is no better way to demonstrate the value of early recognition and the prompt application of modern psychiatric therapy. The support, by a social worker, of a patient after he leaves the hospital—with the goal of solution of daily problems as they arise, help with a job, help with living arrangements, help with changing attitudes of the family group—does build confidence in the institution and show family and community that mental illness is a problem that can be dealt with.

2. *By providing educational opportunities for the medical public.* Many doctors in practice did not receive intensive instruction in emotional and psychological illnesses because they graduated from medical school before psychiatry attained

¹ New York: Grune and Stratton, 1950.

its present importance. As a result some doctors have a pessimistic attitude toward the services of the state hospital.

The family doctor, in presenting the need for hospitalization to the distressed family of a patient with a serious mental illness, might say, "I hate to do this, but there is nothing else that can be done but to send him to the state hospital." On the other hand, a physician who has participated in the medical-care program of the state hospital and who is proud of his work there might say instead, "I think you should go to the X Hospital. You will get good treatment there. I know, for I am on the staff."

One of the best ways to educate the medical public is to invite them to assist in the medical activities of the institution on a part-time basis. Participating doctors improve the standard of care of patients. Direct contact with psychiatric patients and the result of modern treatment give them a perspective that favorably changes their own point of view. They also acquaint colleagues with progress in the public mental hospital.

The state-hospital staff physicians can gain the good will of doctors who send patients to the hospital by writing to them and explaining the illness of the former patient, and indicating the treatment that is being carried out.

When patients improve and are sent home, they can be referred back to their family doctors for after-care. Psychiatrists, furthermore, ought not to isolate themselves within the walls of an institution or within the isolation of their own professional psychiatric societies. Psychiatrists should participate in general-medical meetings, where they will rub elbows with other doctors and become known by them. When called in consultation, they should take care to be truly helpful to the general-medical man and design a treatment plan that he can understand and carry out.

Psychiatrists should also participate actively in the under-graduate and graduate training programs of physicians wherever this is possible.

3. By educational efforts directed toward the general public.

A. Trustees are often the official representatives of the public in the affairs of public mental hospitals. If trustees

are thoroughly familiar with the operation of the institution to which they are appointed and can interpret its problems to their friends and to the governmental authorities with whom they come in contact, they can be most helpful.

B. *Employee Ambassadors.* Employees who live in the community and who have high morale and enjoy their work may be most helpful educators of the public. They help to build confidence in what the institution is trying to do. It is worth all the time it takes to educate employees to understand their rôles and what they may accomplish in patient care and management through their own applied skills.

C. *Volunteers and Auxiliaries.*—There is almost no source of public education more valuable than the person who contributes his service to the public mental institution without expectation of reward. That individual, talking about his experiences to his friends, tends to build confidence in the institution. Just a few examples of the help the volunteers give may serve to illustrate this point.

The Women's Auxiliary of the Boston State Hospital holds an annual spring fashion show for the enjoyment of patients. Some months before the event, women's clubs, churches, and service organizations are canvassed for donations of women's hats and clothing. A committee of women restyle and redecorate the donated hats and clothing, discarding those that are not in good condition. Female patients are trained as models. Their hair is styled by the beauty parlor, and they are gowned to portray the chosen theme of the show—a wedding, a garden party, or some other social occasion. Decoration of the hall is arranged in coöperation with the occupational-therapy department. It is a gala occasion, with music, the fashion show, prizes, and refreshments. Patients look forward to this annual event, and each patient who attends is helped to select a hat that suits her personality.

Other community organizations take patients in bus loads to museums, concerts, ball games, or points of interest in the Boston area.

Still other volunteers provide entertainment of the very best type twice weekly. Radio, television, theater artists in the Boston area are the performers.

Many Boston University students volunteer for work in the hospital. Some of them receive credit in their courses for

this work. The hospital radio system last year was operated entirely by volunteer college students.

A Massachusetts Institute of Technology fraternity, instead of having a "Hell Week" for initiation, arranged a "Help Week." Initiates were sent to the Boston State Hospital to work. They did general housecleaning tasks, and at the end of the week they entertained patients with a talent show.

D. Visitors' Courses. Each year the hospital plans an informative course for relatives and friends of patients, based on the questions most frequently asked of doctors and social workers. This helps them understand mental illness, their part in it and in the group. They see that others have problems similar to their own and gain security thereby.

E. Mothers' Groups. Mothers of schizophrenic patients have been gathered together for intensive group therapy to work out common problems in relation to mental illness.

F. Chaplains' Services. The hospital has three full-time chaplains, as well as a student chaplain, who not only are responsible for attending to the spiritual needs of patients, but play a very important part in interpreting mental illness to relatives. With this help, it is often possible to gain the co-operation of reluctant relatives in therapy. Chaplains also make public talks before church groups and the clergy.

G. Tours and Clinic Demonstrations. Colleges in the Boston Area are encouraged to send classes in sociology, in psychology, and in other subjects, for a conducted tour and clinic, to demonstrate the variety of services given by mental hospitals. Service clubs and other community organizations also avail themselves of this opportunity. As these are held on regular scheduled days, any interested citizen may participate in these field trips.

H. Public Talks. The hospital co-operates with the state association for mental health, which conducts a speaker's bureau and provides films and other audio-visual aids for use in public education. Members of the hospital staff speak to service clubs, P.T.A.'s, churches, women's clubs, high-school assemblies, and so on.

I. Community Service. Medical agencies may sometimes be aided through direct consultation services by the mental-hospital staff members. Similarly, psychiatric help can sometimes be given to schools. Sometimes graduate courses for

physicians in practice can be organized within the framework of the medical society, dealing with psychiatric subjects. In Massachusetts, a section on neurology and psychiatry was created within the medical society, which, at its annual meeting, always holds an important discussion on a topic of interest to general practitioners, illustrating the recognition and management of emotional and psychological illnesses. The state psychiatric society holds its meeting jointly at this time.

Colleges offering courses in social work, psychology, nursing, occupational therapy, sociology, recreation, education, and so on may be given assistance from the staff members of the public-mental hospital who are good teachers, and arrangements for affiliated field training may be made within the hospital. Last year 335 such students were enrolled for training at the Boston State Hospital. Other agencies in the health and welfare field may have case conferences, using hospital-staff psychiatrists as consultants.

Some agencies have arranged group discussions or institutes topically oriented to the needs of the workers, and hospital-staff members serve as group leaders.

Every mental hospital should give assistance to the local association for mental health in every way it can. Staff members may serve on its medical advisory board, and may expect to receive help in securing volunteers, donations, literature, plays, films, and so on from them in return. Furthermore, the state association for mental health, operated as it is by lay citizens, often may have access to the specialist needed to employ successfully such media as magazines, press, radio, television, and films in a public-education program. Radio and television, to be most effectively used, require the guidance of experts in their use.

The legislature, which appropriates the funds needed to operate any public mental hospital, may be reached through the use of brief reports that contain information of a type calculated to appeal to the general public. Too often, reports from mental institutions are dull, stuffy recitations of statistics, containing nothing of an educative nature that could help the public to understand the particular needs of the institution. Informative bulletins and letters also may be used.

The legislative committees concerned with the mental insti-

tutions should be invited to make personal trips to the institution. When they do come, they should be taken to see the troubled areas, not just the pleasant features. Personal contact with legislators also helps, and sometimes the trustees can be most useful in this educative process.

Teachers may be helped through organized courses, field trips, and group-therapy sessions, or through consultation and instruction on the use of the Bullis or other plans for courses in emotional hygiene in the school curriculum. Similarly, other interested specialists can be reached through the media of group discussion, consultations, or seminars.

Problems.—The principal barrier to the undertaking of an extensive program of public education by any state hospital is the limited time that staff members have available for this purpose. As a rule, there is so much pressure for the individual treatment of patients that no time or energy is left over for other affairs. It may be pointed out, however, that public education pays off for the long-range benefit of the hospital's program of treatment. The medical public also demands that psychiatrists donate some of their time, as other doctors do, in free service—namely, the treatment of patients in hospitals and clinics without charge. It helps if fellow colleagues within the medical profession understand that psychiatrists may carry a heavier teaching load, which must usually decrease somewhat their contribution to free hospital work.

Another real dilemma that must be faced is the stimulation in the demand for psychiatric services that any public-education program engenders. Public education usually leads to a demand for more services than exist, or if they do exist, the facilities are already severely overtaxed.

The purpose of the public-education program is to develop self-reliance in others who can help to carry some of the load and thus decrease pressure upon the psychiatric agencies. For the time being, valuable time may be diverted from treatment, but the result in the end should be to the advantage of the public psychiatric mental hospital.

SUMMARY

The value of a public-education program to a state hospital has been discussed. The public needs to be kept informed about its public psychiatric hospitals, their successes and their

failures, and what may be accomplished with more help and more assistance. The public needs to know the results of psychiatric treatment. If the mental hospital is a good hospital, and if it is accepted by the community as practicing good medicine and giving good medical care, it becomes easier to recruit professional workers. It becomes easier also to recruit other hospital employees. There is greater understanding on the part of relatives and greater willingness on their part to coöperate with physicians in carrying out treatment.

Patients who talk about their treatment may also help in public education, doing much to dispel fear concerning the hospital itself.

Citizens who work in the hospital and share in its problems are often its best advertisers, for the hospital then becomes "our hospital, in our community." Informed citizens can put pressure on the legislature to increase financial support; this may relieve overcrowding of patients and shortages in employee quotas. An informed legislature is the best source for meeting the needs of public psychiatric hospitals. There is often a willingness to appropriate funds when the problems are clearly understood.

A public-education program may well involve teachers, pastors, probation officers, public-health nurses, social workers, parents, and citizens. Such individuals, when aware of problems of emotional and psychological illness, are better equipped to deal with them, referring to a psychiatrist or a clinic those beyond their capacity to handle.

A program of public education dealing with problems of mental health and mental illness benefits both the hospital and the community.

AN IN-SERVICE TRAINING PROJECT IN MENTAL HYGIENE

HOW CAN A SOCIAL WORKER ASSIST PUBLIC- HEALTH NURSES IN A MENTAL-HYGIENE PROGRAM?

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AUTHORITATIVE support for the idea that mental hygiene is an essential part of a public-health program is now much stronger than it was twelve years ago, when our present program was first proposed and established. That it is one function of public-health departments to bring to the general public knowledge of mental hygiene, is being recognized more and more widely, both on this continent and internationally.

The report of the first session of the Expert Committee on Mental Health of the World Health Organization includes the statement: "The Committee, therefore, considers that the most important single long-term principle for the future work of WHO in the fostering of mental health is the encouragement of the *incorporation* [our emphasis] into public-health work of the responsibility for promoting the mental as well as the physical health of the community."

In 1939, when plans were originally being made for a mental-health program for the Metropolitan Health Committee of Vancouver, the following statement was made by one of the present authors: "It seems to me if all the physicians and nurses of this organization will take a sincere interest in mental health, opening their minds to its importance, that in the measure that this becomes a constant interest, the organization as a whole will become a potent force in preventing mental disabilities. Moreover, I think that if a whole organiza-

tion of such a size could become thoroughly imbued with this enthusiasm, it would be a pioneer in the field that is almost certainly going to be the site of the great advances in medical practice in the near future."¹

Health education is the keynote of public-health work. The type of teaching in which public-health departments have had most experience and success depends on giving information and help to individual patients and parents about their own problems. It is a process in which the rocks of error and prejudice are worn away by the impact of thousands of drops of information, reassurance, and advice. The public-health nurse is the member of the staff who has most to do with this case-by-case teaching.

In mental hygiene we have a body of principles and practices that can be passed on in helpful form to parents and teachers and others who have to do with the nurture of the infant mind. We have learned, for instance, that each person has his own rate of growth, and that failure to recognize this principle may bring out various forms of unsocial or neurotic behavior. Normal growth depends on the satisfaction of needs; unhealthy personalities come from families where there is a lack of love and objectivity. Respecting and making suitable allowance for all of the many ways in which people differ, physically, intellectually, and temperamentally, is another important plank in the platform of mental hygiene. A theme that does not readily lend itself to the platform metaphor has to do with the disruptive effect of confused values and the therapeutic effect of the harmonious organization of a hierarchy of values.

Nurses, teachers, parents, each group in terms appropriate to their own problems and experience, can be presented with these principles of mental hygiene—and this does not pretend to be a complete list—and shown how they help people to understand and to modify various personal and interpersonal difficulties that make for poor mental health.

But just telling people *en masse* that they should love their children, that they should not push them about, does not mean

¹ From a report proposing a program for mental health in Vancouver, by Dr. C. H. Gundry.

that these principles of good mental health will be followed. We need more than mass education; we must approach people individually and teach them, not abstract principles, but the application of those principles in their own lives. Public-health nurses have taken the principles of immunization and nutrition into homes and schools; now we want them to do the same with the principles of mental hygiene.

If a nurse is to do this job, how can we give her help? The schools of nursing are tending in this direction, but the preparation is still rather sketchy. Although a great number provide courses, there is, as a rule, inadequate provision for the necessary field training and the particular kind of supervision required.

At least until the time when mental-hygiene teaching in university courses for public-health nurses is more adequate than it is now, it would seem that individual public-health organizations will need to develop their own training programs. Attempts have been made to do this in our organization by adding a social worker to the other resources which, for twelve years, had been available for the training of the nurse in mental-health practices.

This paper attempts to show how the social worker in one year has tried to help the nurse. It outlines some of the difficulties anticipated and encountered, and the steps taken to meet them. As a background to the work of the social worker in this setting, it seems desirable to describe in an outline sketch the community and the organization of which he was to be a part.

Public-health services in the Greater Vancouver area are provided to over 500,000 residents, spread over a region of 248 square miles. Both the homes and the districts vary in structure and character. The area of dingy, deteriorating tenement houses, with their swarms of transients and dependent families, and the district adjacent to the harbor, with the descriptive name of "the skidroad," abut on the business section. Some who seek even cheaper living find it in float houses, amid the dismal surroundings of water-front industry. Although it is dangerous to generalize about people, yet it has been observed over the years that many of the residents of this district are irresponsible and indifferent, unresponsive,

though seldom hostile, to the efforts of the public-health nurse. The presence of the large Oriental population in this same downtown area adds a further socio-economic complication.

In the outskirts of the city, there are many families who have found living and working in the city unsatisfying or economically difficult. They have settled in semi-rural areas, where one or two acres of land provide produce that supplements their incomes, permits them the recreation of gardening, and helps to satisfy their feelings of independence. There are many who have come to retire, attracted to Vancouver from other parts of the country. They often come with patterns of life that require modification for contented living, but because of their strongly developed sense of self-sufficiency, or sometimes because of feelings of failure, they are not always eager to accept help.

In addition to these somewhat nonconforming groups that lend a good deal of color to Vancouver, there are those groups that are common to all large North American cities. These are the people who are socially and economically conforming, who see themselves as participating members of the community, sharing responsibilities for its standards and showing enthusiasm for education, civic progress, and personal betterment.

With all these classes of people, the nurse is in constant touch, as she provides a generalized public-health service. Her work includes the duties of a school nurse, attendance at child-health centers,¹ follow-up of tuberculosis cases, and tracing venereal-disease contacts. She does a great deal of home visiting in connection with these and other duties and so she gains a valuable fund of knowledge about the families in her district. This background knowledge naturally helps her greatly when she has to try to help a family in which social, emotional, or more narrowly medical problems have arisen. All age groups, all economic classes, from the unemployed and the untrained laborer to the university graduate, furnish the material with which she works.

When one considers that the health of over 50,000 school children, ranging in age from five to eighteen, was under the nurses' surveillance in 1950, and that out of 9,879 babies born

¹ These may be known as well-baby clinics elsewhere.

in the same year, 6,212, along with their mothers, were seen at the baby clinics, the extent of contact with the community becomes more meaningful.

To carry out such a program, an agency structure has been developed over the years to suit the particular needs of geography and community.

Administratively, the senior medical officer is responsible to the Metropolitan Health Committee, which consists of representatives from the various municipal bodies that are being provided with health services. These are channeled through the numerous divisions of the organization. Each division—mental hygiene, nutrition, sanitation, nursing, and so on—is directed by a specialist who in turn is responsible to the senior medical officer.

The nurses, doctors, and sanitarians who serve the community work from the six health units into which the area is divided. The staff in each unit functions under the direction of a unit director and a nursing supervisor who are the administrators on the spot.

The total personnel in 1950 numbered 224, of whom 95 were nurses, 17 doctors, and 13 dentists.

It is important to note that the senior medical health officer, who himself had had training in psychiatry, lent complete and constructive support to the mental-hygiene program and provided leadership for its acceptance. If a mental-hygiene division is to be an effective part of a public-health organization, the leader of the organization should not only give his nominal support to mental hygiene, but should understand its scope and limitations.

It is within such an agency that our mental-hygiene division operates, with a staff of two psychiatrists, two psychologists, and one social worker. Our aim is twofold—educational and preventive. We have attempted to use cases as teaching tools and have not viewed them primarily from the treatment angle. Until November, 1948, the division of mental hygiene had only one person allotted to it—the psychiatrist. The policy was to use public-health nurses as fully as possible, in finding and preparing cases for clinic study, and in following up the recommendations. Although we have not receded from that position, or from the position that our main function is preventive and educational, not therapeutic, several methods of

improving our work became apparent as time went on. We found that the line between advice and treatment was a zone and not a line; we had to undertake some therapy, because there simply weren't enough therapeutic clinics or practicing psychiatrists. The addition of a second psychiatrist and two psychologists to our staff enabled us to study more cases, and especially to offer more treatment.

In terms of psychotherapy our work continues to be—and we think should continue to be—very superficial, but the cases we treat would not receive treatment if we did not provide it.

The other direction in which we felt that our work required strengthening was in "staff education." The services of a social worker were obtained to help us with this. That is the part of the picture with which this paper is primarily concerned.

The second psychiatrist was added in the winter of 1949, and except for a period from January, 1950, to December, 1950, has been with us since. From November, 1948, to July, 1950, one psychologist carried the testing load, but from September, 1950, we have had the services of two psychologists. The social worker has been with us since September, 1950.

While working in the schools and child-health centers, the nurses spot cases and refer them to the mental-hygiene clinic. They deal, in the first instance, with the teacher and the mother who ask for advice and help. To do this adequately and satisfactorily, they must know the difference between what is "normal" and what is not.

In addition to interpreting this to the community, the nurse will make the social investigation and explain the meaning of our clinic and how it can be of assistance.

On the day of examination, a conference is held under the direction of the psychiatrist, with the psychologist also in attendance. It includes various people particularly interested in the family, but basically aims to have unit director, nurse, teacher, and principal present.

During the conference, the nurse participates, first, by presenting the social facts verbally, and, second, from her knowledge of the family, by sharing in the planning.

In a great number of cases, the nurse continues to visit the home, to observe to what extent the parents are implementing

the suggestions of the clinic and what change is occurring in the child's behavior.

Some of the observations which led to the conclusion that we needed to give the nurses more help and training were as follows:

The social histories sometimes contained only a minimum of facts; sometimes they were much like silhouettes, shadowy and rather indistinct. This could be attributed to several things: first, the nurse's training, in which the importance of confining herself to facts had been stressed; second, the nurse's own feeling that she did not have time to get a long history; and third, her lack of security in dealing with personal topics. In regard to this last point, some of the nurses felt that just as they would not wish to have their own lives investigated, they would not wish to probe into the lives of others.

Sometimes, nurses would fail to follow up their cases, with the result that the cases would be lost to the clinic. In many of the cases that were followed, there seemed to be a poor grasp of treatment principles or an inability to meet unexpected resistances.

The social worker's main task was to provide specific guidance to each nurse in her function as detector of emotional ills and dispenser of mental hygiene. Because of some of the resistances known to be present, it was felt that it would be necessary to move slowly. Some of the nurses—as a result of their dealings with social agencies in which they had received the impression that they were interfering in case-work situations and had been refused information on the grounds of its confidential nature—were a little suspicious of social case-work and any one in any way practicing it. Others felt that social workers did not act quickly; made promises of visiting, but did not keep them. Other nurses, on the other hand, who felt that they themselves were inadequately trained and too heavily burdened with other public-health work, were more than willing to let a social worker carry all the mental-health cases.

As background to this whole unrestful atmosphere existing between social worker and nurse, was the philosophical question, What is health? Did it mean physical and emotional, indivisible and inseparable, or could the nurse attend the physical without touching the emotional? Some social workers

maintained that the nurses were trained in problems of "physical" sickness and "organic" disease, and that was their field. Let those who were trained to understand the behavior of people handle family upheavals and emotional problems. The attitude of some social workers, in action if not in words, would seem to be tending to renew the old artificial division between mind and body, and some nurses, more at home in dealing with the "physical" than with the "emotional" aspects of ill health, were content to let them have their way.

To convey to the nurses the fact that the social worker in our organization was an integral part of their service, he had to familiarize himself with their duties and be sufficiently flexible to respond quickly to their requests for help. He had to establish himself as a member of the organization and to live down the initial suspicion that he was an outsider from a suspect profession coming to offer advice. Here the supervisors of nurses proved to be invaluable. They explained the services and emphasized where their particular unit was lacking in strength and how the lack could be filled. We were aware that the reception of a program depends a great deal upon the support of the administration.

Although the social worker's function had been outlined in a general way to the whole staff, he visited each unit separately and spoke to the separate staffs. Thus he was able to hear for himself the expression of the needs of the group and the individuals within the group. The nurses were given an opportunity to ask questions and were recognized as individuals with unique feelings and needs. The social worker accepted their statements and indicated that he would be willing to discuss with them at a later date some of the questions they had raised.

As a result of these visits, one of the functions of the social worker took a definite path.

A discussion of social histories—their structure, their value, the kind of material needed—was conducted with all the units. Not only was this helpful in revising the guide for preparing a social history, but it proved to be an extremely effective technique in teaching mental health.

By using the content of histories already written, it became relatively easy to point up that when we speak of disturbed

children, we mean children who are upset in or unsure of or bewildered by their relationship with parents or siblings. We illustrated inconsistencies in the descriptions by asking how such statements as, "Father and mother get along well," or, "This seems to be a happy home," could explain such behavior as "stealing, lying, truancy, daydreaming."

Granted that these ideas had already been presented in conference, yet to point them out by direct reference to work done had greater meaning to the nurses. Some of the nurses objected to what they regarded as criticism by declaring that the statements were answers to questions asked of the parent who was being interviewed. This stimulated discussion around the value of social histories and the importance of the observer's impressions.

It was quickly brought to light in these group discussions that the nurse often had many more impressions of the family under study than she had recorded. Sometimes, because of her training as a nurse, she had not allowed herself to give expression to her feelings about the case. The groups responded immediately to the suggestion that their evaluation of the home situation would be of great value to the clinic. They saw that their own feelings were legitimate data for discussion if treated objectively.

In addition to these discussions, since there appeared to be an over-all demand for help in interviewing, a series of eight talks was given to two of the units—*i.e.*, about thirty nurses. Because of lack of time, it was not possible to do the same for all the units, but they might be carried on in other years with the remaining units.

With the individual nurse, another pattern was developed. In each conference, which centered around a case already seen at the clinic, the case was considered from several directions: *first*, how thorough an understanding did the nurse have of the case; *second*, what did the nurse feel she could achieve in the rôle that had been assigned to her; *third*, how far did she think she could interpret the suggestions of clinic or social worker in working with the people in the home and the school; and *fourth*, how could the case be used to convey more vividly and meaningfully principles of mental health.

Reviewing the social factors and interpersonal relationships in each case provided numerous opportunities for teaching

and widening the nurse's horizon. For instance, we could discuss the meaning of stealing in the particular case under consideration, and go on to show how stealing could have different purposes under different circumstances. The nurse herself often raised questions of what change could be expected and how it might take place. These were specific requests which resulted from the nurse's own needs and which were important to her.

It was in this particular area that the clinic conference was deficient. Although the clinic attempted to give meaning to behavior and to devise some constructive steps to help both parents and school, the presence of other professional people restricted to some extent the nurse's participation. There may have been questions she wished to ask, but she felt constrained for several reasons, such as her own feelings about the teacher, her own feelings of inadequacy in talking about principles of mental health, the traditional nurse-doctor relationship. Then there is always the lack of time; conferences were scheduled for half-hour periods.

The conference with the social worker gave the nurse an opportunity to express her ideas and to ventilate her feelings. At that session her own doubts and problems were the *raison d'être*. Any differing ideas she may have held were brought into the open and we referred back to the case to discover the reason for her position.

It was found that the nurses varied widely in their understanding. Some would attribute behavior too largely to one particular factor, such as the presence of a grandmother, or jealousy of other siblings. Others overlooked the importance of parent-child relationship and laid undue stress on sibling relationship. These and other instances probably revealed the way an individual's own experience and feelings affect his judgment. Some would describe the situation in minute detail and fail to realize the varying weight of each of the influences, indicating confusion in selecting a point of focus.

Invariably the nurse's rôle involved numerous complications. One or two felt, for instance, that it was almost impossible to work with a parent who herself happened to be a registered nurse; others were reluctant to become too intimate with parent or child because of their own conflicts and lack of interviewing skill. Many more, on the other hand, were able

to see that they, as nurses, and particularly as public-health nurses, did have a part either as observer, or as a link between clinic and parent, or as a support to the parent in time of strain. Recognizing that there was always the chance that inadequate parents might become very dependent on the nurse, we indicated how this might be avoided, but found that practical limitations obviated its occurrence. Those nurses who did not appear to have much confidence in themselves were seen in conference often and helped step by step; those who revealed a greater grasp of behavior and were willing to do more were given specific guidance, always with the caption that there was a limit to what any one could do.

This led directly to an exchange of ideas about community resources, their lack and their availability. What are we going to do with the fourteen-year-old boy who has been expelled from school and rejected and neglected by his own parents? If he is supervised by a social agency, what can the agency do for him?

Through such discussions the nurse became more aware of the difficulties, points of view, and limitation of other groups in the community who were doing mental hygiene. This helped to dispel some of her impatience with social workers, so that the working relationship was facilitated.

At times, when the nurses were not satisfied with the work of our own psychiatrist and psychologist, it was necessary to emphasize the limitations of psychiatric treatment. Psychiatrists have been plagued by being expected to provide cure-alls.

A phase of the work that was touched upon in each conference dealt with the nurse's difficulties with the teachers and principals. A number of the school staff did not believe in the kind of mental hygiene we were advocating, nor did they feel that they derived much help from attendance at the clinics. This attitude made it doubly difficult for the nurses to carry out their program.

To overcome this, the social worker visited several of the schools and spoke, either personally or in conference, with some of the teachers. Arrangements were made by the nurse for a clinic session to be held in the school, thus giving all the teachers an opportunity to attend the conferences.

With each nurse, specific suggestions were made as to how

the teachers could help the child in the classroom. Since many of the teachers argued that the classes were too large and that they had no time to deal with the individual child, we thought the nurse might ask the teacher to do the best she could under the circumstances. We would point out to the nurse that there were some teachers who, in spite of the size of the class, would say, "What can I do to help?" It was important in working with the teachers to discover the degree to which they were willing "to go out of their way."

To the objection, "I've done everything the clinic recommended and Johnny is still disrupting the class," the nurse could acknowledge the difficulties of the teacher's position and discuss some of the principles of growth and change. The attempt was made to help the nurse feel sure of her ground, so that she could transmit some of this confidence to the teacher. That was our guiding principle.

In assessing the social worker's part and how much was accomplished, one must know, too, the proportion of time he spent with the nurses. Because of other demands, he visited each unit on an average of two days per month. The remaining days were employed to keep records, visit agencies, give staff talks, attend meetings, and finally do case-work with a select number of children and adults. This last mentioned function was considered to be important, for it meant the availability of social case-work services within the organization, and the demonstration of skills, knowledge, and their blending, to nurses who, because of their training, might be a little skeptical of social case-work.

Measurement of the extent to which the nurse has been helped in the past year to work more effectively in the area of mental hygiene cannot be made on a scientific basis. However, there were several indications from the nursing staff itself that our progress was in line with our original purpose.

At the close of the group talks to the two units, which included such topics as "The Interviewer," "The Interviewed," "The Interpretation of Behavior," "Making Referrals to Our Clinic," "Obtaining a Social History," and "Interpreting Follow-up Reports from the Clinic," the nurses were asked what the course had meant to them.

These are the comments of 26 nurses in their own words:

	Number of nurses
Helpful in making referrals.....	2
Brought greater awareness of own self and attitudes.....	7
Served as review of principles.....	6
Helpful in obtaining social histories.....	13
Gave greater understanding of individual and his reactions.....	13
Valuable in the rest of their work.....	3
Too idealistic and impractical.....	2
Specific principles mentioned:	
1. Accept client, but not necessarily his actions.....	2
2. Allow client to share in plan.....	1
3. Begin where client is.....	1
4. Focus on problem.....	1
5. Allow client to talk.....	1
6. Do not give advice.....	1
7. Principles of interviewing to be adapted to each situation	1

The results revealed that not only were principles of mental health being integrated, but that interviewing techniques were being noted. Since the nurses had not been told in advance that they would be asked for their opinions, it was felt that these answers had real meaning and indicated the areas wherein they had received the greatest support. That is to say, the nurses' statements that they were realizing the importance of knowing one's self and one's attitudes, and of greater understanding of behavior, signified to us that we were hitting the mark with regard to our aim in helping them.

Other specific evidence that we could assess was the social history. A change was noted from statements of a few bare facts to personality pictures with descriptions of social factors. One got the feeling that the nurse had really visited the home and had understood something of the drives, frustrations, and inadequacies expressed and observed in the interview.

It has been noticed that those nurses who had been diffident are becoming more willing to make suggestions and to take responsibility. They are asking questions as to where the trouble may be. Some have been making contributions to teachers and parents in planning for the modification of the child's program as a step toward altering his behavior. Others, knowing that responsibility is being shared with the social worker, have become more confident in their relationship with child, teacher, and parent. Many of them are beginning to feel

less discomfort when behavior is not modified and to show clear and accepting understanding of the continued disturbance.

To us this means that the nurses in our organization are showing signs of being more acutely tuned to mental hygiene.

The kind of service that is being provided by our social worker is certainly consistent with our principle of making each member of our public-health organization "a potent force in preventing disabilities."

THE MENTAL-HEALTH CLINIC AS A THERAPIST IN THE COMMUNITY

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MUCH has been written about mental hygiene, and most of the work that has been done in that area has been dissemination of intellectual information through pamphlets, lectures, movies, and radio programs, in attempts to change the attitudes, feelings, and behavior of people toward better mental health. Information is important, but it alone is not enough. In order to stimulate positive changes in the mental health of a community, it would seem necessary for the clinic to reach out into the community and work with groups on an emotional level. Intellectual insight alone does not produce constructive changes. This article is an attempt to point out some ways in which a mental-health clinic might have far-reaching effects on the mental health of a community.

Most clinics cannot treat effectively all the persons that need help. Some workers in the field believe that clinics large enough, with enough trained personnel, could handle the enormous problem of mental illness. From the point of view of preventive medicine and public health, this is wishful thinking. Most clinics merely scratch the surface, so far as giving help to all who need it is concerned. As long as a clinic operates primarily or solely on an individual-treatment basis, it must fail the greater needs of the community for preventive mental hygiene on a community-wide basis. The mental-health clinic is in a unique position to act as stimulator and catalyst to help the community find the resources within itself which can resolve some, but by no means all, of its mental-health problems.

Mental health should be the concern of the entire community, and until this comes about, very little progress can be expected. Too many people want to dump the burden onto psychiatry entirely, and many people in psychiatry feel that they and they only have the wherewithal to do the job. If the clinic adopts the attitude that it alone is capable of handling the

emotional problems of the community, it paradoxically may make the community dependent on it for answers rather than able to begin to accept responsibility for some of the changing itself.

If, however, the clinic as a group can find the security and strengths within itself to accept its responsibility to do community work and really tackle the larger problem of mental health in the community, believing that people can and do help themselves individually and collectively—that a community has strengths as well as weaknesses, and that individuals (as well as communities) do have inherent capacities to grow and develop into maturity—then it can be a potent force in helping society to resolve some of its conflicts. Therapeutic potentials are present in many individuals as well as in society. The psychiatrist, the psychologist, and the social worker are not the only individuals so endowed. If all these potentials could be brought together and developed, society could not help but be positively affected by them. At the center of such a development, the mental-health clinic could be a major factor in inducing such a movement, if, in its relations with the community, it could assume the rôle of therapist as often as possible, rather than the rôle of lecturer and information-giver on an intellectual level.

In the rôle of therapist, the clinic must develop a sensitive ear to pick up the cries for help in various areas of the community—cries that may come through many channels. Quite frequently they are expressed through significant individuals and groups of people in the community, such as teachers, ministers, physicians, nurses, industrialists, and social agencies.

But this developing of a sensitive ear that will hear cries for help in a community is one thing and only the beginning of the task for the therapist-clinic. By refusing to take all of the responsibility for the problems presented to the clinic, by confronting individuals or groups with responsibility for their conflicts and their need to resolve them, and then by offering help in terms of making it an emotional experience through which they can gain new strengths and insights, the clinic can help the community to better mental health.

For example, the clinic often is asked by groups of teachers for a lecture on the emotional problems of children. This

invitation could be accepted at that level and a good lecture produced which would permit the teachers to sit back passively and take away whatever they might be interested in getting. Some of the information might be used effectively, some of it distorted, some not used at all. If, however, the group can be confronted with what it is in many instances actually asking for—namely, how can they as teachers, coming into intimate contact with children every day in schoolrooms, help children grow emotionally—it might then be possible to offer the teachers a group experience in which they would have to participate emotionally to some degree, which could help effect some constructive changes in their attitudes, feelings, and behavior in their relationships with their students. Through the medium of such a group experience, they could begin to work through some of the emotional blocks that impair their own functioning.

In the spring of 1951, this approach was used with an elementary-grade school when a request came to the clinic for a lecture. It was amazing to see how quickly the entire faculty accepted help for themselves once the above-mentioned factors were made clear to them. Three sessions were requested. After evaluating the experience themselves later on, they wrote us:

"It made us explore ourselves and see in what ways we were contributing to the problem and that the solution must come from within. It gave us more understanding of each other and brought us to the realization that we all face similar problems. Putting ourselves in the child's place made us more aware of the child's feelings and the causes of his behavior. . . . We would like to continue this study next year and wonder if you would be able to give us help."

If this kind of experience can be made meaningful in an emotional way for the teachers, all the students, not just one, can be helped. If this kind of experience can permeate the entire school structure, the possibilities, mental-health-wise, are almost unlimited. It is hoped that more of this kind of work will be done in the schools and that, as more data become available, the findings will be published.

Adhering to these concepts, when we were approached by certain members of the faculty of Armstrong College, of Savannah, for help with their counseling program, we were able to help them set up a program with potentialities of developing into a real mental-hygiene program for the entire

college. We refused to get involved in the impasses that arose between the counselors and the rest of the faculty, but we offered the counselors the opportunity of working through their own problems through group sessions with the clinic staff. The result was that for the first time in two years they, as a group, found within themselves the strengths to work through their initial difficulties with the rest of the faculty.

After this the counseling group asked for help with their individual-counseling cases, and when they began to get more emotionally involved in the group sessions, they began to work on themselves. Several persons asked for individual-therapy hours along with the group meetings.

Gradually the group (now augmented by other faculty members who joined the group) came around to talking about what they could do for the students. They worked on this and sold the college the idea of giving the incoming freshman group a college-orientation course which would run for the entire year, in which the students would be given the opportunity to explore themselves, their thoughts, feelings, attitudes, and behavior in small groups, the faculty hoping that through such an experience, they might be helped to see themselves and others in such a way as to be able to get more out of their everyday living and to be better, more productive individuals in the community.

This program, which includes group Rorschach testing of the entire freshman class, both before and after this year's experience, has just begun and already has assumed the proportions of a potentially very fruitful research project. It has been very interesting to note that whereas at the beginning of our struggles, only six members of the faculty participated, the number has increased to fifteen. This larger group now is interested not only in helping their students expand their intellectual horizons, but also in helping them grow emotionally. The details of how this started, how it progressed, what took place in this process, some implications and potentialities, will be discussed in a paper at a later date.

In a somewhat similar way, the clinic team has been giving group consultative service regularly each week to such social agencies as Child Placement Services and Family Service of Savannah, and just recently a group program has been started with the public-welfare department. Also, similar group

work has been begun recently with the entire group of public-health nurses at the local health center. Plans are being made for starting similar work with some ministers.

All of these programs are being evaluated as we go along, in the hope that by exploring the processes involved we may be able to discover more of the secrets of how a community might help itself change its cultural patterns to help more of its people grow into maturity without suffering the ravages of emotional disorders.

It is believed that if a mental-health clinic is going to accept the challenge that is constantly confronting it in terms of trying to help the individuals of a community and the community as a whole with their emotional problems, it must assume the rôle of therapist as frequently as possible. It must develop a sensitivity to needs. It must be able to provide an emotional experience for the community through which groups can gain new strengths and insights, and, in short, gain maturity. It must be ready and willing to relinquish its own rôle once the job has been completed. It is quite conceivable that a mental-health clinic so oriented could be a potent factor in inducing an emotional chain reaction which, over a long period of time, could lead to the resolution of some of society's conflicts and could reduce the number of cases referred to the clinic so that eventually it would be utilized purely as a treatment center for the more difficult cases.

FELLOWSHIP HOUSE: A SMALL-GROUP RESIDENCE FOR ADOLESCENT BOYS*

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THIS is a preliminary report of an experience with a small-group residence for maladjusted adolescent boys, set up in a large urban community. Because of the relatively brief duration of our study—two years—our observations permit us to draw only the most tentative conclusions, which will be discussed later. We are offering this report because of the widespread interest in the project described in this paper.

The Jewish Child Care Association of New York is a placement agency. A few years ago the agency was confronted with the urgent need of placing a small number of its adolescent boys who, because of their age, were ready to be discharged from its institutional divisions, Pleasantville and Edenwald. These young people were not fully prepared to live alone or to accept family living, either in their own homes or in foster homes. For these boys, Fellowship House was set up, modeled on an experience of many years' duration with the agency's Friendly Home for Girls, described elsewhere by one of us.¹ There are very few other reports in the literature discussing experiences with disturbed adolescents cared for in small-group residences in large communities.²

This paper is a study of the first 27 admissions to Fellowship House, which was established to serve the purpose of a short-term placement of from six months to a year. At the time of admission, the boys ranged in age from fifteen to seventeen and a half. Their school placement was from the

* Presented at the Twenty-eighth Annual Meeting of the American Orthopsychiatric Association, Detroit, February 23, 1951. The authors wish to express gratitude to Dr. David Beres, the consulting psychiatrist of Fellowship House, and to Miss Bess Davis, case-worker, for their inspiring help and coöperation in the course of this study.

¹ See "Friendly Home and Fellowship House," by Sarah Sussman, a paper read at the National Jewish Conference of Social Work, Atlantic City, New Jersey, June 6, 1950. To be published.

² Two that might be mentioned are "Adolescents in Action," by Carmelite Janvier (*American Journal of Orthopsychiatry*, Vol. 13, pp. 82-88, January, 1943) and "Dorsoris—An Experimental Study and Treatment Home for Adolescent Girls," by Aileen C. Burton, Judith Wallerstein, and Viola Bernard (*American Journal of Orthopsychiatry*, Vol. 19, pp. 683-96, October, 1949).

first to the fourth year of high school. Their I.Q.'s ranged from 78 to 128, and followed the bell curve in their distribution.

Of the total of 27 in the study, 25 boys came to Fellowship House directly from an institutional placement. Two-thirds of these boys had been in foster homes of the Jewish Child Care Association before going to the institutions. All of these boys had a history of unsatisfactory adjustment in the foster homes, which was the specific reason why they were all replaced in the institutions.

The adjustment of these boys at the institutions varied considerably. Some had had a stormy course throughout, while others had settled down after a year or two. But when they had reached the age of discharge from the institutions, they still were not ready for close family living. This was the end result of the psychic traumata these boys had suffered as a consequence of the emotional deprivation that they had experienced in early childhood either in their own homes or in institutions, which had led to disturbances in object relationship in all of them.

Many of the children cared for by the Jewish Child Care Association have suffered similar traumata. Most of them recover from the effects of the early deprivations under the influence of the corrective experiences afforded them in foster homes or at the institutions, Pleasantville and Edenwald. But the boys in this study would appear to have been traumatized more severely by their early deprivation. For, despite their having gone through the same type of corrective experience, they needed the further experience of a set-up like Fellowship House to reach the point where they, too, could accept living with their own families or in foster homes.

The total population of the Jewish Child Care Association is about 1,200 children. The 27 boys in this study, who appear to have made the least satisfactory adjustment, therefore represent a very small percentage of the total.

Sixteen of the cases in this study would come under the classification of "Character Disorder" in the sense of the psychoanalytic concept of character which defines it in terms of the functioning of the ego.¹ Others would include these 16 under the category, "Psychopathic Personality." We

¹ See *The Psychoanalytic Theory of Neurosis*, by Otto Fenichel. New York: W. W. Norton and Company, 1945.

have avoided using this term and have substituted for it diagnoses that describe our cases more adequately in terms of their psychic structure. Thus we would subdivide them as follows: six fit into the subgroup, "Psychic Immaturity," in which the ego and the superego function on an infantile level, with little evidence of intrapsychic conflict. The other 10 belong in the subgroup, "Neurotic Character." We made the diagnosis of psychosis in two cases, both of which are schizophrenic, but have never required hospitalization. Three were diagnosed as schizoid, and six showed a predominance of neurotic manifestations. All of those admitted to Fellowship House so far have been chosen because they showed varying degrees of difficulty in adaptation. This would account for the fact that we have no so-called normal boys in this study.

Fellowship House is located in a four-story house in the heart of New York City. It was completely renovated, re-decorated, and furnished. It has a spacious living room and dining room, and a large game room. The bedrooms have three and four beds each, offering accommodations for a total of 16 boys. There are also accommodations for members of the house staff.

The house staff consists of a resident supervisor and his wife, and a counselor, who acts as a recreation worker and as assistant supervisor. The counselor, with the help of the supervisor of recreation, plans the recreation activities in the house and makes contacts with community resources for the boys.

The responsibility for administering Fellowship House rests with the association's special-services department, which carries on its activities in a separate building which houses its staff offices. Here the boys come for their interviews with various members of the professional staff, such as the vocational-guidance and scholarship supervisor, the case-worker, and the staff psychiatrist. The case-worker has the usual duties and responsibilities for the integration of every facet of each boy's living. She is also the case-worker for Friendly Home for Girls. It is she who is responsible for helping the boys and their parents make plans for return to their own homes. When this is not feasible, she plans with them for

foster-home placement or some other arrangement when they are ready to leave.

The psychiatric services available to Fellowship House are as follows: The staff psychiatrist's functions include diagnosis, treatment, consultation with the case-worker, and supervision of panel psychiatrists. He participates in a variety of conferences relating to case-work, psychiatric problems, and policy. He sees every boy who has had a history of previous psychiatric reference, usually at the time of admission and at any other time thereafter when indicated. Boys who are in need of continued psychotherapy and who cannot be seen by the staff psychiatrist are referred to one of a group of panel psychiatrists in the community. Few of our cases are amenable to psychotherapy because of the nature of their difficulties. So far, only two boys have been carried in continuous psychotherapy while at Fellowship House. We also have the services of a consultant psychiatrist, with whom the professional staff meets regularly.

All but three of the boys in this study have shown some improvement during their stay at Fellowship House. Even in these three there was no regression in their behavior patterns. Although a few of the boys who had come from institutions had been serious behavior problems up to the time of their transfer, only one of them persisted in this pattern at Fellowship House. He had a long history of stealing and this behavior continued during the few months he was at Fellowship House. He was a case of kleptomania. Other than this, there was relatively little stealing. On the whole, there was a definite diminution of destructiveness.

Most of the boys worked regularly on a full-time basis or went to school and worked part time. Many paid their own board and learned how to budget. Three of the boys graduated from high school during their stay at Fellowship House. Of these, two went on to college on scholarships provided by our agency. Besides these two, during the time covered by this study, 11 boys were discharged from Fellowship House, after an average stay of six months to a year. Five, who had no homes to which to return, were able to accept foster-home placement. The other six were able to return to their parents. This represents a definite improvement in that dur-

ing the institutional placement of most of these boys, we find notations in the histories to the effect that their interpersonal relationships with adults and with other children were on a superficial level. In addition, there is the fact that they were not ready to accept close family living at the time of admission to Fellowship House. During their stay at Fellowship House, most of these boys appeared to form a better object relationship with adults, including resident supervisor and case-worker, than had been reported at the institutions they came from. These results are reported with a full realization of the fact that this study covers too short a period to come to any definite conclusions.

We now come to a consideration of the factor of group cohesiveness among the boys at Fellowship House. We have given this problem a great deal of thought because of the recognized value of group formation in the development of character, especially through identification.

The process of group formation at Fellowship House is well described in the words of the resident supervisor, in a report he submitted at the end of its first year of operation:

"In reviewing the activities engaged in by the boys of Fellowship House, it is notable that the newcomers at first are so affected by their new freedom that they 'want to be on their own.' Acceptance at Fellowship House seems to carry with it a recognition that they are grown up now and may come and go as they choose.

"There is no objection, of course, on the part of some to team participation in sports. But hardly any 'buddy' relationships have developed. The boys show an inclination to do things in groups of two or three, depending on the specific activity of the moment, rather than on the basis of their being pals. The fact that boys room together or attend the same high school does not carry over into their other interests. The boys constantly are grouping and regrouping themselves, not only from day to day, but from hour to hour, on the basis of a particular interest or activity of the moment, rather than any personal kinship."

This reminds one of the play activity of young children, with transitory grouping as one of its chief characteristics.

During the second year at Fellowship House, there has been some change in the above picture. Small groups of three or four boys at a time are beginning to appear. They will stick together for a while, but this is not long lasting. There are still few activities involving the entire group. It is still true that the boys do not choose one another as best pals or buddies. This, despite the fact that most of them had known

each other for several years at Pleasantville, before they came to Fellowship House. These boys do not have any best friends or "buddies" anywhere else, either. Also, they participate in group activity elsewhere much less than others of the same age.

When the boys were offered free tickets to any amusement, such as a sporting event or the theater, only a few would accept. And these few would usually go to the event as individuals. Sometimes a boy would announce that he was going to the movies and ask who else wanted to go with him. If another boy did accept the invitation, it was never a case of either one saying, "Let's see who else wants to go." The current picture seems to indicate some improvement over a year ago, when there was a more outspoken tendency to rugged individualism.

Whatever group pressures are discernible usually operate only in small groups. For instance, the boys sleep three or four to a room. The other boys will usually see to it that a slothful roommate will make up his own bed. There is little evidence of total group pressures. Apparently there have been few occasions for this so far. Very little direct authority has been delegated to the group. For instance, on the question of taking turns at serving at the dining-room table, we have given the group as a whole the responsibility of seeing to it that the system of rotation functions properly. We are frequently reevaluating the question of how such authority should be delegated to the boys as a group.

There are many questions that this study leaves unanswered. Despite the improvement of most of our boys, there remained a residue in the picture of each one that we couldn't reach with our present methods. That is why we cannot report that the boys were restored to anything approaching so-called normalcy when ready for discharge.

Another question relates to the amount of guided activity within the house. Other authors differ on this issue. Perhaps we will have to modify our approach in the direction of more guided activity within the house. We wonder whether our boys are not in need of this because of their relative immaturity, at least in certain areas of their ego development. Of course, our present policy is based on the fact that we wish

to encourage them to seek community recreational resources in anticipation of their leaving us after a relatively short stay. But during that time perhaps we need to combine more house activity with the other.

We may encounter difficulty even in such efforts. The resident supervisor has observed that the boys often react to organized group activity as if they want as little of it as possible. Can this be a reaction to the many years most of them spent in institutions with well-organized, usually adult-planned, programs? It is as if other adolescents rebel against parental ties through group formation, while our boys react against institutional group living by becoming individualists. But we will continue to try to learn more from our experiences in order to improve our technique of encouraging a more cohesive relationship within the group.

We would also like to be able to bring out more readiness for psychotherapy in the boys under our care. This has not proved easy so far, again because of the types of personality difficulty encountered. These boys seem to prefer direct discussions of their immediate questions and nothing more. This has gone so far that the resident supervisor had the following to report: when a boy would come in with a question about sex, he wanted an answer only to that question. He would reject any suggestion the supervisor might make of inviting some one to talk to the entire group on the subject of sex.

Part of our experimental technique is to determine the optimal relationship between permissiveness and authority. This is in keeping with the approach in all divisions of the Jewish Child Care Association, including Pleasantville¹ and Edenwald.

We have relatively few rules at Fellowship House. But even these few rules we try to apply in a very flexible manner, to meet the individual needs of each boy, as stressed by Aichhorn² and others. We did not start off with the idea of being completely permissive. We, too, had to learn through our own experiences where to draw the line. For instance, when Fel-

¹ See "Psychotherapy in a Resident Children's Group," by C. P. Oberndorf, in *Searchlights on Delinquency*, edited by K. R. Eissler. New York: International Universities Press, 1949. p. 165.

² See *Wayward Youth*, by August Aichhorn. New York: Viking Press, 1944.

lowship House first opened, each boy was assigned a closet of his own, without a lock on the door. Although some of us had misgivings about this from the start, the attitude that won out at the beginning was the one that went along somewhat like this: we want to look upon ourselves as one big family, each one trusting the other implicitly. But after the occurrence of a few stealing episodes, and our observing how disturbing these were to the victims among our boys, we changed our policy and put a lock on every closet door.

We are apparently in a transition period on the question of the relative balance between authority and permissiveness in the handling of children and adolescents. Fortunately, we seem to be witnessing a swing away from the extreme of complete permissiveness, practiced by some, which apparently was a reaction against the former philosophy of "spare the rod and spoil the child."

There is increasing evidence in the literature of a growing awareness of the need to be highly flexible in the degree of permissiveness allowed. For instance, in 1938, Slawson¹ discussed the value of an authoritative case-work approach in the field of delinquency, especially when dealing with immature narcissistic clients. More recently Bromberg and Rodgers² emphasized this approach in a report of their experiences in the psychiatric treatment of a group of delinquents between the ages of seventeen and twenty-five in a naval prison during the last war. They state that "when the therapist by his firmness and understanding supplies a parent figure in whom reality elements of authority and love are experienced, considerable relief is afforded." We get a similar reaction from a different source in papers by Hacker and Geleerd³ and by Wright and Leitch,⁴ who relate their findings

¹ See "Use of Authoritative Approach in Social Case-Work in the Field of Delinquency," by John Slawson. *American Journal of Orthopsychiatry*, Vol. 8, pp. 673-78, October, 1938.

² See "Authority in the Treatment of Delinquents," by Walter Bromberg and Terry C. Rodgers. *American Journal of Orthopsychiatry*, Vol. 16, pp. 672-85, October, 1946.

³ See "Freedom and Authority in Adolescence," by Frederick J. Hacker and Elisabeth R. Geleerd. *American Journal of Orthopsychiatry*, Vol. 15, pp. 621-30, October, 1945.

⁴ See "Use of Boarding Homes in Conjunction With a Private Residential School," by Dorothy G. Wright and E. Mary Leitch. *American Journal of Orthopsychiatry*, Vol. 16, pp. 74-83, January, 1946.

in the treatment of severe cases of adolescent maladjustment at the Southard School. We have purposely chosen the above examples because they seem to have this in common with our cases: they are all instances of maldeveloped ego and superego structures. In such cases external authority may have to be supplied not only for proper guidance, but also for control of internal anxiety.

The aim of our whole program is limited. It includes keeping a young person on his job or in school and improving his relationship first within a group and later in a family setting. We are dealing with individuals in whom we see varying degrees of retardation of emotional growth, but in whom there are nevertheless present healthy factors whose development we can assist, even if we cannot influence them directly, to paraphrase Beres *et al.*¹

We would stress the fact that we have not had to contend with any cases of delinquency. This, despite the fact that some of our cases would fit into the category of latent delinquency as this term was used by Aichhorn.² The corrective experiences these boys had undergone at Fellowship House, and before that in other divisions of the agency, have protected them from those provocative conditions that might otherwise have resulted in their becoming cases of manifest delinquency. We believe this to be true because of the fact that the case histories of our boys are so similar to those of cases of overt delinquency with this important exception: the relative infrequency of any corrective experiences in the lives of delinquents. This suggests another advantage of a set-up like Fellowship House—*i.e.*, to aid in meeting the problems of delinquency.

It is of interest to find a trend similar to the one just referred to in reports by Kate Friedlander³ and Dorothy Archibald.⁴ According to these authors, the English Parliament has passed several laws which finally led to the establishment

¹ See "Psychiatric Program in an Agency Serving Youth," by David Beres, Virginia Schaeffer, and Julia Goldman. *American Journal of Orthopsychiatry*, Vol. 16, pp. 84-89, January, 1946.

² *Op. cit.*

³ See *The Psychoanalytic Approach to Juvenile Delinquency*, by Kate Friedlander. New York: International Universities Press, 1947.

⁴ See "Some Services for Difficult Boys," by Dorothy Archibald, in *Searchlights on Delinquency*, previously cited.

of hostels to which judges in children's courts may send youthful offenders appearing before them. We have not seen any detailed account of how these hostels operate. But we were interested in the following brief reference in Archibald's article: "The great advantage of hostels over approved schools is that they do not take boys out of the main current of young people; that there is less 'discipline' and the boys can be sent there for as short a stay as six months. Above all, there are hostels where probation cases are mixed with ordinary young people to the great advantage of the probation cases."

The general idea of the whole set-up at Fellowship House is to provide a living arrangement that approximates normal family living in a large urban community and yet does not make demands on the boys too rapidly.

THE ORIENTATION OF STAFF IN A HOME FOR THE AGED*

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IN a general hospital, medical and surgical treatment of patients is taken for granted by the staff, who rarely become disturbed by pathology, procedures, or patient behavior that would excite panic, revulsion, exorbitant and useless pity, or even anger in the usual person. This equanimity is the result of an education and training that give "meaning" to the situation, so that the signs and symptoms of the ill person are viewed as evidence of, and response to, disturbing stresses from within or without, and the treatment process or the investigator's procedures as reasonable means toward a goal—the restoration of health in the individual in question.

In a home for the aged, for the most part, there is the same sensible approach. However, as may happen even in psychiatric hospitals where certain members of the staff are unfamiliar with the "meaning" of psychiatric disease, the reaction of responsible personnel may be influenced in some degree by fright and horror. Such reactions seem minimal when the aged person is simply "organically ill," are moderate when "psychiatric disease" appears to have its basis in "organic disease," and are most in evidence when the illness cannot easily be traced to such roots and has obvious psychological ramifications, or results in behavioral disorder that is organically inexplicable or is understandable only in terms of "cerebral degeneration."

Even where "organic disease" is the primary process, aged individuals tend to provoke some anxiety in those who are called upon to care for them.

The dependent, clinging, passively sabotaging, or resentful behavior of the maladjusted aged provokes anxiety in the staff member when he or she does not recognize this dependency or cannot understand it for what it is: evidence that stress is being experienced and responded to by the aged ill one. When

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it is seen and understood as an adaptive manoeuvre, such anxiety is minimal or does not arise.

In the Home for Aged and Infirm Hebrews, staff psychiatric conferences have been used as an educational technique in an intensified program of psychiatric treatment and investigation. Such conferences, in which current problems of management and disposition are considered, have made it possible to discuss the disturbed behavior of aged residents with the purpose of decreasing the anxiety of personnel as well as of furthering the evolution of team work in treatment. Obviously, proper management requires that a minimum of anxiety be provoked in each staff member involved. Toward this end, specific problems that arise are dealt with in accordance with the following point of view. This point of view is developed, in so far as the case material permits, systematically over a period of several months.

Behavior Disorders in the Aged.—In a home for the aged, we are called upon to deal with many kinds of behavior disorder. What we can do depends on our skill and knowledge, the facilities and personnel available for use, and the modifiability of the disordered behavior that confronts us. What we can do depends also on the attitudes and goals of the community in which we work; these may limit our efforts or urge us to full performance.

In general, the psychiatrist places emphasis on: (1) restoring the person to the greatest possible degree of social usefulness; (2) assisting the person to live with satisfaction, comfort, and dignity; (3) minimizing the complaints of the environment about the person. This latter goal, of course, one always tries to achieve without curtailing the first two. It is obvious that one does not treat any one in a vacuum; in a home for the aged, as in the community, one must respect the "rights" of other persons as well as the patient's, and the occasional disturbed person whose behavior is unmodifiable by less stringent methods must, in some degree, be restricted to permit others a useful, comfortable life.

Some specific problems that arise are: (1) estimation of potentialities dangerous to the self or others; (2) management of "disturbed," recalcitrant, quarrelsome, or otherwise troublesome persons; (3) proper disposition of persons who make excessive demands on the particular community; and (4) esti-

mate of the eligibility of such persons for admission to particular institutions.

When confronted with a problem in disordered behavior, what is our procedure? In general, we seek the answer to four questions: What kind of person was this? What kind of person is this? What kind of person will this be (if no modifying influences are brought to bear)? What kind of person can this be if we use whatever modifying measures are available to us?

The first question we answer as best we can by history taking: family history, past personal history, and that of the present illness. The second, we answer by means of our physical examination and determination of mental status. The third is answered by extrapolation in the light of our accumulated knowledge, the patient's life situation and environmental influences being taken into account. To answer the fourth, we must consider the patient in terms of his intellectual and affective resources, viewed from a dynamic point of view in terms of the established mechanisms of psychological adaptation.¹ One of our best means of estimating these resources is study of the patient's past record.

We also consider the possibilities of altering the situation, the better to enable the patient to make a satisfactory adaptation. The environment must also be evaluated in terms of the possibility of the patient's altering it to suit himself better if we can help him achieve his maximal capacity for adaptation.

We are, of course, interested in the person's general appearance and behavior, in his stream of speech, his grasp and comprehension, the relevance or irrelevance of his answers to questions, trends toward circumstantiality or clear goal of conversation. We must make some assay of his mood or affect at the time of the interview and some estimate of what it has recently been. We note the content of his thought. We are most interested in his preoccupations; his ideas about the people and institutions he deals with; his feelings of worth, self-confidence, acceptance; his habitual methods of adapting to the world in which he lives.

We pay particular attention, in the aged, to the intellectual resources. We note orientation to time, place, person, and situation, memory remote and recent, retention and recall,

¹ A term borrowed from Dr. S. Rado.

calculation, general information, judgment, and we evaluate the person's insight into his own difficulties.

Having sought the answers to these questions, what do we find in the aged?

The aged individual is often found to have lost certain basic and all-important resources. One of these is memory. So far as we know, this is the correlate of diffuse cortical damage. Now anticipation depends on memory, and controlled anticipation appears to be the totality of what we call reasoning. Thus, reasoning and its corollary, judgment, are impaired with memory loss.

The loss of such a resource results in what we see as a degree of dependency—a person unable to care for himself with his previous efficiency, who, to survive, may need our help. Seen from the affected person's point of view, this dependency is a degree of helplessness. This helplessness is either new and fresh for the person (if he has been a rationally directed, emotionally mature, maximally self-reliant person), or it may be merely a reinforcement of preexisting dependency. The person's behavior is then reorganized along the lines of his previously established mechanisms of psychological adaptation. He may view this dependency as: (1) a situation of great vulnerability in which damage is constantly threatened or certain; (2) a situation in which great care and protection is naturally to be expected; or (3) there may be a combination of these two points of view.

If the helplessness is viewed as vulnerability, there is fear. We may see this manifested as general nervousness, apprehensiveness, with restlessness, panic, or immobilization. If the expectancy of protection is great, the way is paved for frequent and great frustration.

In all this we must not forget that the loss of memory itself, and all the pleasures thought entails, is itself a deprivation—a frustration on a grand scale.

With all this, what may we further expect?

The previous mechanisms of psychological adaptation determine the patterns of behavior that emerge. The individual, in his dependent state, tends to revert to childhood and to reorganize his behavior along the lines of seeking help from those about him. This may be viewed as search for a

parental figure. This "plea for assistance" may take the form of obedience in a passive manner or may be actively appeasing and ingratiating, to obtain and hold the sought-for "parent." The helpless person may be defiant—passively recalcitrant, waiting for great gifts from the parental figures, to whom, in his state of helplessness, he is inclined to attribute his troubles, or he may be actively angry, turn demanding, and try to force the loving care he desires. Resentment and anger may be so strong that the environment is constantly attacked in a paranoid manner, or they may be turned against the patient himself ironically, to excite our sympathy or with a sense of defeat, which is seen by us as depression.

Thus, all the complicated elaborations of once useful emotions over which control has been lost may show themselves in the setting of dependency resulting from the aging process. However, we have in these persons an additional factor on which these complicated mechanisms of adaptation are superimposed—the defects in apparatus and function.

Of these defects, or lost resources, we have thus far considered only one—the loss of memory. Other resources are lost as well. There are, for example, disturbances of the perceptual apparatus—the eyes, ears, and other sensory organs. The muscular system suffers. Homeostatic mechanisms (the means of maintaining internal equilibrium in the face of the changing environment) both acute and longer-acting, are diminished in efficiency either on systemic grounds or because of the alteration of function of links in the sequential chains of integration.

The sensory-neuromuscular integrative system suffers and the individual is unable to cope with the changing environment in the two basic ways. First, he is literally not up to mastering or escaping from environmental changes; and second, he is unable to maintain his internal equilibrium in the process of attempted mastery or escape. In fact, in the aged as in the very ill, we may see varying defects in maintaining the internal equilibrium under conditions of minimal stress. This of course leads inevitably to death of the organism.

We are dealing, then, not merely with the effects of rage and fear on the development of the individual and with the inhibitions that result, causing, for example, indecisions, doubts, inertia, impulsiveness; but we are dealing with inabil-

ity to act based on defective apparatus, the effects of which are all-pervasive. The defects in the apparatus for effective action result in a lack of freedom of action of a primary kind. Such limitation of the person's function by itself leads to doubt, indecision, fear, and rage. It is often difficult to say, in such states of disordered behavior, how much is on the basis of defect, and how much is secondarily provoked, emotionally determined inhibition of function in reaction to the failures made inevitable by the defective apparatus.

At any rate, it may help us now to consider our own reactions to the dependency of the aged and its manifestations.

Staff Reactions to Aberrant Behavior.—It is not uncommon for aged persons to be viewed as "pathological museums," whose medical study, treatment, and management are tedious and unprofitable. Their illnesses may be seen as hopeless and our treatment of these "degenerative" and "deteriorative" processes as futile. Many are repelled by the incontinence, self-neglect, or slovenly helplessness of the aged. A "broader view" is often taken in which the care of the aged person is resented or deplored as time wasted because "they have only a short way to go" and were possibly "not worth much to start with." These are obviously hostile attitudes.

On the other hand, there may be a tendency to view the aged as "cute," "darling," "sweet." Pity, sympathy, compassion, desire to help the distressed, now so helpless and in need, may be dominant attitudes. A "broader view," stressing duty to fellowmen and striving toward the relief of distress and the saving of lives, may be paramount. These seem to be compassionate, loving attitudes. As evidence of acceptable acculturation, they are creditable, but they may be excessive and harmful.

These reactions, both overly hostile and overly loving, are viewed in the following way: These patients frustrate us. Their dependency is onerous; we are busy; they cling to us like children, yet they are not children. On the contrary, they are usually older than we—the sort we have been inclined to look to for help, feeling disappointed if we do not receive it. In short, these people point up our own unsatisfied dependency patterns. We feel our own inadequacies and helplessness and become anxious.

In addition to this threat to our dependency needs, they are

reminders of what may happen to us, too. They are reminders of our own vulnerability, our own inescapable mortality. This epitomization of our own fundamental helplessness is a further threat.

Our reaction is to be anxious, fearful.

How do we show this? In terms, of course, of our own previously established mechanisms of adaptation. The usual patterns fall into two large groups: (1) the excessively compassionate—usually serving no purpose; (2) the hostile, which meets threat with threat, dominates, rejects, overrides.

Instead, it seems preferable, wherever possible, to deal with the motivations of the patient in a rational, goal-oriented, modifying way. Within this framework, of course, compassion is possible and helpful; within this framework, threat may meet threat with knowledge of its practical efficacy where punishment sought must be administered, if this is the shortest route to the final goal of restoring a maximum of independent functioning in the sufferer.

If we react to the extreme dependency of the aged with anxiety because of the threat it constitutes to our own dependency needs, and in the presence of this anxiety show either useless compassion or unreasonable anger, this leads only to further frustration of the patient and of ourselves, precluding our goal of dealing with the motivated behavior of the patient in a rational, modifying manner.

Therapeutic Orientation.—We often have at hand methods of placing the organism in the best situation to favor and hasten those natural healing processes that can occur in the aged. We should use these whether they are medicinal, or physical, or involve situational manipulation. We also attempt to find the residual assets and put them to use, thus serving society and the person by permitting him satisfactions which, in turn, favor continued contact with reality in a context of reasoned rather than emotional motivation.

The staff psychiatric conference is useful in indirectly bringing to the awareness of personnel their own attitudes of fear provoked by dependency and its manifestations. Our own anxiety and its concomitant sense of helplessness to deal with the situation result in our immobilization or in demands for help from outside instead of in rational attempts to find a solution of the problem. Rage and hostility may

override, leading to punitive or other rejecting measures. Compassion may prevail, but without usefulness in helping the aging person. Rational action toward helping an individual resident in the home may be taken if we start as informed, reasonable persons, self-reliant within our function and willing to carry it out for the benefit of the resident in question.

What is stressed in staff conferences is that there is really no question of "functional," or "organic," "psychogenic" or "somatogenic" in the handling of disordered behavior; rather there is the question of what can we measure or note, by what method we can most accurately describe the processes, so that we may choose and put to use effective methods of treatment (modifying measures).

Our classifications have too much been derived from methods of investigation and treatment used and too little from our understanding of disease as a disturbance of vital equilibrium which we can help correct not by one method alone, but by one of many separately or together. Healing, repair, is after all the task of the organism; we have at hand now many, now few or no methods of placing the organism in the best situation to favor and hasten this process. We use whatever is at hand that works, and constantly seek more efficient, faster remedies.

At present, the treatment of these behavior disorders in terms of what has been and is being done is usually oriented toward gratification of the dependency strivings or by forcing the patients toward non-threatening (to us) inhibition and withdrawal. It would seem to be more reasonable to find the assets of the person and to try to put these to use, thus serving both society and the person by opening the way to self-satisfaction which will favor continued contact with reality, a broadening of this contact, and a decrease in the person's need for magical fulfillment in a setting of "parental care."

Always to be kept in mind, nevertheless, is the fact that with many aged persons the illusion must be fostered and maintained that all-embracing "parental" care and protection is continuously present or available.

A FOLLOW-UP STUDY OF A GUIDANCE-CLINIC WAITING LIST*

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FOR many years child-guidance and mental-hygiene clinics throughout this country have been under severe pressure from case loads greater than staff strength to meet them. In the interest of doing careful, high-quality work, most clinics have devised waiting lists for all but the most emergent problems.

It has been the common experience that when people are re-contacted after any considerable waiting period, many of them state that they no longer need clinic service; or if the matter is left to the patients themselves, a large number do not re-contact the clinic after a stated period. Frankly, our staff tended to doubt whether this was really due to lack of need for the service. We thought that many people who need service were using this as a defense because they had been in effect turned down in the first place. On the other hand, harassed staff workers, when contacting patients again, might well accept their not coming back readily and with relief. They might even unconsciously encourage them not to come back.

With these questions in mind, we did a follow-up study by telephone to determine what had actually happened to patients who had applied for service at this clinic, but had been refused at the time of application because of a long waiting list.

Seventy-two persons were interviewed in all. The waiting period they had undergone varied from several weeks to six months. At the time of their application, by clinic policy the patients were told either to call back at the end of a stipulated time, which was usually several months, or were told that the clinic social worker would call them back as soon as an appoint-

* This study was made possible by a grant from the Hogg Foundation for Mental Hygiene.

ment became available, but that it would probably be several months away. The study was confined to those persons who had applied for service during the past five years and could not be seen when help was requested, and who did not call for an appointment, or did not keep the one offered them at a later date.

The telephone interviews were conducted by a trained medical social worker, working entirely in the area of research. She had no connection with clinic policy and was not responsible for the care of patients coming to the clinic. The interviews on the phone were conducted with the patient if it was an adult, or if the patient was a child, it was discussed with the parents. All the people contacted were told very frankly the purpose of the study and were not offered service at this time. If they initiated a request for help, they were referred to the same intake procedure as any other applicant. The research worker inquired primarily into the questions of whether or not the patient got help elsewhere, whether or not the problems about which they sought help still existed, and how the patient or family had dealt with the problem.

It was striking throughout the interview how much positive interest was encountered by the social worker when she reached these people. The research procedure was, in itself, a "reaching out" process, and even though it was done on a research basis, it still demonstrated some interest in these people and their problems. They showed uniformly an eagerness to discuss their problems and their reasons for not coming to the clinic when appointments were available.

Exactly one-half, or 36 of the total of 72 persons interviewed, still stated that the problems for which they had come had cleared up or that they no longer had them. In 19 instances the problems had cleared up of their own accord and through family effort. In six cases school attendance or new teachers had seemed to help. Three more children had been helped by going to private speech therapists or schools of voice correction, and one child's thumb-sucking had been cured by a trip to the dentist, who talked to the patient. The mother did not know what the dentist had told her.

One patient went to a private physician who gave him vitamin shots for "nerves," and the mother reported that the child was all right at the time of our follow-up. She explained

that the patient had lost his father shortly before his application to the clinic and seemed bothered a great deal by it and was hard to get along with. One mother read books and cured her child's enuresis in that way. Another parent said that she got help from the lectures given at school by the members of the child-guidance-clinic staff. Four patients were treated by private psychiatrists and reported that they no longer had problems.

Thirty-six, or one-half, of the patients interviewed, stated that their problems still existed. These people had not gone elsewhere for help, but were either discouraged by the long waiting period or had lost the impetus for taking time to seek help by the time their application was reached. Many thought that the problem would improve of its own accord, since often the acute stage had passed during the waiting period. Sixteen people reported that the problem was somewhat better since the acute stage had passed, but seven expressed a desire to return to the clinic at this time, and five actually made application again to the clinic through the regular channels. Two parents felt that things were going along better now, but needed reassurance that they could call the clinic at any time it was necessary. Two others stated that the problems had improved and they did not feel that help was necessary now, but it was apparent from their description of the situation that many of the original factors about which they had sought help were still present.

Among those families in which a problem still existed, five stated that they could not afford the private psychiatric care to which they had been referred, and one reported that he was unable to get a mutually satisfactory appointment with the psychologist who was suggested to him. Three people had tried going to private physicians who gave varying types of treatment, but the problems were not cleared up. Two patients tried going to private psychiatrists, but the families were not satisfied with the results.

With no exceptions these people felt that they would have benefited from clinic service at the time they had made application. They voiced such opinions as, "I wish the clinic could reach more people at the time they need help"; or, "When they put me off for so long, I just had to forget about it"; or, "I needed help at once." One mother was "sorry you couldn't

see me when I called as it would have meant a great deal to me." One family had been referred to a family agency in the community when we could not see them at the clinic, but they felt that this was beneath their dignity and did not go.

It seems quite clear from the experience of this study that many problems for which help is requested at a child-guidance clinic do not necessarily clear up during the waiting period just because the family does not return later or because they say they do not need help any more. Many factors operate to deter patients from coming in after being put off for a long time. In general they are discouraged, they feel rejected, and something about the timeliness of the original need is lost in the grinding process of clinic scheduling.

Secondly, it seems clear that when the clinic reaches out even by means of this simple research device, people really are still quite interested. The chances are that if staff members had a "reaching out" attitude all of the time, their waiting lists and their burdens would be even heavier than they are. However this is going to be handled administratively, it should be pointed out, and in full sympathy with the pressures under which most staffs operate, that whether we reach out or not *does* make a great deal of difference as to how many people use the clinic. We should not delude ourselves or those responsible for the administration and financing of clinics into thinking that people don't need help just because they don't call back or because they don't say that they need help when they are called.

Finally, we present additional evidence that the waiting period is a discouraging and rejecting experience. This will not be a startling or new discovery to staffs and others interested in child-guidance clinics. We believe that too much emphasis cannot be placed on this fact. There is real reason to reëxamine intake policy and waiting periods continuously. We are not at all convinced that stacking people up on a nice hourly schedule is either the best or the most efficient way to handle problems. People feel a need for help when they feel it and not when it is convenient for others. It is quite possible that it would take less time to assist people if our system of dealing with their problems could be more flexible when they first come to our attention.

These are admittedly matters of clinic policy and those

responsible for this might decide differently in one situation than in another, and one clinic group could well have different goals from another. At any rate, the facts as to how patients react to the waiting period, as brought out in this study, should be matters of serious concern from a purely professional point of view, on the one hand, and from a public-relations and financing point of view, on the other.

THE SLEEP FUNCTION AND SLEEP DISTURBANCES*

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I. THE NORMAL SLEEP FUNCTION.

THE increasing use and abuse of soporifics in recent years, and the increasing number of intoxications and suicides by means of soporifics, have rather grimly made the treatment of sleep disturbances a subject of current interest.

One cannot divest oneself of the impression that many doctors feel insecure and uncertain before the treatment of sleep disturbances. The sleep function to them is a very vague concept, and all too often the treatment is limited to a prescription for a soporific. *Since soporifics alone can never cure sleeplessness*, trouble often arises: a tendency develops to a protracted use, or abuse, of soporifics, tablets and medicine bottles accumulate in the home, and the result sometimes is attempted suicide. The physiology and pathology of the sleep function may, however, be treated as rationally as any other medical problem, as this paper will attempt to illustrate.

Researches on the problem of sleep have not been lacking. A problem that so naturally suggests itself has of course interested physicians and other investigators from the earliest times, and Pieron, in 1913, could report in his classical work, *Le Problème physiologique du Sommeil*, no less than 3,000 works on sleep. Only a minority of these works, however, are of interest to-day, except from the historical point of view, and the experience they represented was not sufficient for a general synthesis that would be serviceable as a foundation for our understanding of sleep, both in the field of research and in practical work.

Later—and especially in the years after World War I—researches into the sleep function have followed fixed tracks, and the sleep function is now being mapped out scientifically,

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in the best sense of the term. Of course there are still a great many points that are obscure, as there will continue to be important neurophysiological problems that have not yet been clarified. So much has been established, however, that it is possible to give a rather exhaustive description of the physiology of the sleep function, and, using this description as a base, to indicate in a general way the lines that the treatment of sleep disturbances will have to follow.

First, let us define our concepts. Sleep, in the general sense of the term, constitutes only one part—albeit the most conspicuous one—of the total sleep function. Kleitmann summarizes the more important criteria of sleep as follows: (1) a loss of critical reactivity to events in one's environment; (2) an increased threshold of sensibility and reflex irritability; and (3) an ability to be aroused or brought back to the state of wakefulness. Thus, a person may reflexly hit out with his hand at a fly if it disturbs him in his sleep. As a rule one does not hit it because one is not able to take aim in one's sleep when the functions of the cerebrum have been disengaged. Moreover, the criteria include a partial suspension of the psychic, motor, and sensory functions as well as of the more or less easy wakability that characterizes sleep in contradistinction to pathological unconsciousness.

On the other hand, the criteria fail to mention anything about changes in the vegetative functions, and one might ask the question: Does this mean, then, that these functions do not change during sleep? With this question we approach one of the fundamental problems of the physiology of sleep. For it appears that while certain psychical and somatic (*i.e.*, motor and sensory) functions change instantaneously in falling asleep and waking up, so that these changes are characteristic of sleep proper, no such changes occur in vegetative functions. But in other respects vegetative functions are very important links in the *mechanism of sleep function*: (1) the sleep function is regulated by a superior *sympathetic* center in the hypothalamus; and (2) certain vegetative functions are subject to characteristic diurnal variations, incorporated in the sleep function in that special changes occur as a precursor of, and prepare the way for, sleep proper, which they then regulate by serviceable variations during sleep. These

functions are, therefore, designated as *vegetative sleep preparedness*. *

Thus we have—in addition to the concept of *sleep* in the general sense, based on the criteria already mentioned—*vegetative sleep preparedness* and the extended concept, *sleep function*, comprising the total complex of physiological processes that induce and accompany normal sleep. I now propose to review as briefly as possible the individual components of the *sleep function*.

All investigators are agreed that in the hypothalamus, near the aqueduct of Sylvius, (a channel connecting the third and fourth ventricles of the brain) a center is located that is of significance for the regulation of sleep, but it has not been possible to reach absolute agreement as to its manner of working. Economo, whose classical studies on epidemic encephalitis (popularly known as "sleeping sickness") have broken new ground in this field, thought that there was a *Schlafsteuerungszentrum*—a sleep-regulating center—consisting of an anterior, upper center of wakefulness and a posterior, more caudally located sleep center, which in inflammatory irritation produced, respectively, insomnia and hypersomnia. Economo's conception of the regulation has recently been partly confirmed by the studies of the Dutchman, Nauta, but most other investigators reckon with only one bilateral center, which, according to Hess, acts as a sleep center, while Ranson and his co-workers look upon it as a center of wakefulness.

It would take too long to go into detail concerning this most interesting discussion, which is so significant for the whole problem of sleep. For the present, however, we may rely safely on Ranson's conception, which is based on the finest and most carefully conducted experiments on a very large body of material. In his conclusion Ranson states:

"The hypothalamus is the center for integration of the sympathetic and somatic reactions involved in emotional expression, and its activity produces a thoroughly excited animal with active visceral and skeletal musculature. . . . It is probable that the active hypothalamus discharges not only downward through the brain stem, spinal, and peripheral nervous system into the body, but also upward into the thalamus and cerebral cortex. This upward discharge may well be associated with emotion as a conscious experience. . . .

"It is reasonable to assume that elimination of the excitation caused

by hypothalamic activity is responsible for the somnolence and that under normal conditions the hypothalamic drive plays a large part in maintaining the waking state. . . .

"All the evidence from this series of experiments points to the lateral hypothalamic area as the region, bilateral destruction of which leads to somnolence. It is the same area the stimulation of which produces most readily combined sympathetic and somatic excitation, the sham rage syndrome. Small lesions bilaterally placed in the caudal part of this area caused marked disturbance in the capacity to regulate body temperature. . . .

"Stimulation of the hypothalamus results in the formation of hormones, adrenin and sympathin which become distributed through the body in the blood stream and serve to spread, reinforce, and prolong the automatic excitation."

A great number of experiments with injection of various substances into the third ventricle or the hypothalamus strongly support Ranson's conception. The calcium ion, reducing the irritability of the nervous tissue, and potassium cyanide, which is inhibitory to oxidation, both promote sleep, while, when injected alone, the potassium ion has an exciting effect. The sympatheticus-paralyzing ergotamin produces somnolence, whereas atropin, which stimulates the parasympathetic nerves, has no influence on sleep.

The main result of these experiments is that sleep and excitement—or at any rate the somato-vegetative components of these phenomena—are opposite effects of the activity of the same hypothalamic center, in the manner that excitement incorporates an increased activity of the center, sleep a lowered activity; and, in addition, the differences in activity are combined with corresponding differences in a fairly generalized sympathetic activity.

These results have been obtained on the basis of animal experiments, but the aforesaid relation between the function of the center and sympathetic activity makes it possible to transfer the experiments to man, in whom it is possible to study various vegetative functions in relation to sleep.

Since the hypothalamic center is also a superior center for the vascular regulation, it is natural to study this regulation, partly by measuring the peripheral skin temperature, partly by the plethysmographic method.

By means of a special apparatus which makes an automatic photographic registration of skin temperature of the toes and rectal temperature, the diurnal variations of the tempera-

ture were studied in a series of patients. These studies showed that, when certain sources of error are avoided, distinct rises in the skin temperature are in evidence following the after-dinner nap and a night's sleep, indicating lowered activity of the sympathetic center. Furthermore the rise in skin temperature appears *prior to* sleep, indicating that the vegetative sleep preparedness comes as the necessary precursor or foundation for sleep.

Sleep preparedness is established as a consequence of the internal regulation, while the onset of sleep can take place only when a series of exogenous conditions, such as quiet, darkness, and so on, have been provided.

Sleep preparedness is generally most pronounced at the onset of sleep, or shortly after, as shown by a maximum of the skin temperature of the feet at this moment, before it again decreases in the remaining period of the sleep as a counter regulation that sets in to prepare for awakening.

During an uninterrupted night's sleep, variations can be seen that closely resemble the classical sleep-depth curves, with a first and highest maximum during the first one or two hours, followed by a relative minimum, corresponding to light or interrupted sleep. Later there is a lower maximum before the final decrease in sleep preparedness sets in as a preparation for awakening. The experiments may be said to demonstrate such an expedient regulation of sleep that we may consign ourselves to the arms of Morpheus with even greater confidence than before.

When the skin temperature is increasing, the rectal temperature decreases, as a reflection of the skin temperature. The fall is conditioned by the increased loss of heat during sleep preparedness.

These diurnal variations are, however, by no means hard and fast. They are dependent upon constitutional factors and the mode of living, and, hence, follow a fairly regular rhythm. But they are greatly affected by a change in the mode of life, such as work in changing shifts, and they are also influenced by medicaments and meals.

Following the ingestion of benzedrine, 15 milligrams, in the morning, a decrease in skin temperature will appear. Temperature again will rise shortly after each succeeding meal. Also, a normally high skin temperature will occur at night.

In a subsequent experiment conducted on the same subject, 15 milligrams of benzedrine was given in the evening at the time when sleep preparedness usually appeared, and the temperature fell regardless of the first meal, whereas a rise was in evidence after the next two meals. The first time the sleep preparedness was not sufficient to put the subject to sleep, but the second time, at 7.30 in the morning, he fell asleep immediately. The usual nocturnal decrease of the rectal temperature failed to appear, owing to the unusually low skin temperature—and by this finding we are afforded convincing proof that the normal nocturnal decline in rectal temperature is brought about mainly by the increased loss of heat, and not entirely by a decline in muscular activity and metabolic rate, as formerly assumed. This hypothesis has been further supported by direct measuring of the metabolic rate.

In the course of the years, a great number of studies on other vegetative functions have been undertaken, and a closer scrutiny of these studies has given the result in all cases that the reduction of the sympathetic functions may appear *before* sleep and may increase during initial sleep, in complete analogy with the variations occurring in skin temperature. These, however, are the easiest to demonstrate, and because of lack of time I shall have to deal more summarily with the other examinations.

First, I want to mention briefly the relation between the sympathetic and the parasympathetic function. Hess, as is well known, has advanced the theory that in the full waking state, there is a preponderance of sympathetic function and during sleep a preponderance of the parasympathetic. He bases his view mostly on the fact that the pupil is contracted during sleep, a definitely parasympathetic phenomenon. This, however, is a relatively isolated phenomenon. The most significant factor in the rhythmic diurnal variations is the sympathetic variation between vigorous activity in the daytime and decreased activity during sleep preparedness and sleep. During the reduced sympathetic activity, it is easier for an isolated parasympathetic activity to unfold itself, but it is not possible to speak about any generalized parasympathetic preponderance. The difference between the adrenergic and the cholinergic biochemical activity accounts for this. Epinephrine can be carried with the bloodstream and contributes toward

a generalization of a sympathetic activity which is confined to a limited area, or in some cases, is entirely localized, while acetylcholine immediately is destroyed in the bloodstream and parasympathetic activity is consequently always limited to a relatively localized area.

Among the clinically most important vegetative changes that occur during sleep preparedness—which, moreover, vary with the depth of sleep—should be mentioned the lowered secretion of a series of glands. The secretion of tears decreases at a rather early stage of sleep preparedness, giving a sensation of dryness and itching of the eyes. When feeling sleepy, children say that the Sandman is there. The secretion of the mucilaginous glands decreases, so that a coryza does not inconvenience the sufferer during sleep and starts again only during wakefulness. Similarly, the mouth feels dry during sleep—not only in people who sleep with their mouths open.

The acidity of the gastric juice increases with sleep preparedness, and simultaneously the amount of fluid decreases. This point should be borne in mind in dealing with patients suffering from ulcers of the stomach and gastritis. The secretion of bile is lowered during sleep, as observed especially by Swedish investigators, who have also found a marked diurnal rhythm of the liver function. As to gastrointestinal peristalsis during sleep, conceptions are somewhat varying, which may possibly be taken as an indication that this function is not essentially altered during sleep, something that is in keeping with clinical experience.

Night urine, as is well known, is of a very different composition from day urine. The output decreases appreciably during sleep preparedness (that is, also without sleep). Night urine is more acid, with a distinctly lowered *pH*, it contains more magnesium, ammonia, and phosphorus, but less potassium, sodium, chlorine, nitrogen, urea, and amino acids. The lowered nocturnal output of urine should be borne in mind in giving treatment with sulfa drugs, which, as everybody knows, may precipitate in the uriniferous tubules and produce anuria if the output of urine is low already. In such therapy, beverages in the evening and, if necessary, also in the night, should be prescribed.

Quite mechanically, the horizontal position produces a higher output of urine, especially in patients with edemas. This

effect may in certain cases overcompensate the output-reducing effect of sleep preparedness, and hence such patients—especially older people, in whom sleep preparedness is often less pronounced—are frequently troubled with nocturnal micturition.

These inconveniences are aggravated by a generalized tendency to development of edemas during sleep, which is associated with the peripheral vascular dilatation already mentioned. It is thus common knowledge that the face may become swollen and the features blurred during sleep; similarly, girdles, ribbons, wrist watches, and so on, may become too tight if they are not loosened before the wearer goes to bed. Furthermore, a dilution of the blood occurs, partly because of the static conditions with a lowered content of albumin, but an increased content of chlorine and phosphates, whereas the hydrogen-ion concentration changes but little, the decrease in the pH having ranged from 0.02 to 0.06.

The secretion of sweat does not generally change during sleep. Only if the surrounding temperature is so high as to render difficult the normal giving off of warmth during sleep—as in the case of people who sleep covered up by thick, heavy feather beds, and of certain neurasthenics—the peripheral vascular dilatation will not be sufficient to promote the necessary loss of heat, and hence a vigorous secretion of sweat sets in at times. Night sweats, as is well known, are a prominent symptom in febrile conditions—*e.g.*, tuberculosis. However, as will be seen, other possibilities—such as being too warmly covered up, or neurasthenia—have to be considered before a patient with night sweats is suspected of suffering from tuberculosis. Again, nocturnal attacks of anxiety, or dreams involving a state of anxiety, may be accompanied by considerable secretion of sweat.

The pulse rate is lowered merely by prolonged rest. By the employment of electrocardiography, a prolonged conduction time is found—equally pronounced during rest and sleep. The pulse rate decreases evenly in the course of the night and thus appears not to be correlated with sleep preparedness. Organic tachycardia—*e.g.*, thyreotoxic—does not slow down during sleep, in contradistinction to neurotic tachycardia, and this has been helpful to some authors in making this—often rather difficult—differential diagnosis.

The systolic blood pressure decreases evenly during the first two hours of sleep, after which it keeps fairly constant till the subject wakes up, probably also mainly due to mechanical causes. The diastolic blood pressure does not change appreciably.

The changes in the somatic nervous system of sensory and motor functions in relation to sleep differ very considerably from those of the vegetative functions. While the latter are attached to sleep preparedness, the somatic functions change in close relation to sleep. A close study of the changes of the somatic functions will, therefore, supply a good deal of information about how and when we sleep. Most of you no doubt have seen what happens when a person falls asleep. You have seen a man sitting in a train nodding his head, as he is about to fall asleep. Suddenly his head drops forward, but is immediately straightened with a jerk; the process is repeated a couple of times; gradually he experiences some difficulty in straightening it; and with each nodding movement his head comes further and further down, until eventually his chin rests on the chest, and there it remains as long as it is possible for him to be fast asleep in this somewhat uncomfortable position.

This observation is not merely a matter of curiosity; it tells how the actual onset of sleep always takes place. Only, it is not possible to follow the process in persons lying comfortably in their beds. It can be studied in greater detail, however, if the respiration movements are recorded; then a typical change of expiration will be observed. In general, this is considered to be mainly a passive movement, but experiments show that in restful wakefulness a modest, but distinctly active factor is present in expiration which is absent during sleep. This brings about a characteristic change in the recorded respirations, so that merely by reading the respiration curve, one can see when the experimental subject is asleep and when he is awake, as demonstrated in my doctorate thesis, *Studies on the Respiration during Sleep*.

Records of the pressure from the respiratory valve show that in sleep the expirations have a distinctly lower pressure than during the waking state. The pauses regularly seen after each expiration during wakefulness always disappear during sleep. So, in these two ways a sleep expiration can be

distinguished from the expiration of wakefulness. At the onset of sleep we encounter the peculiar phenomenon that first a brief sleep period appears a few times—indicated by a single sleep expiration or a part of such in respiration otherwise of the waking type—followed by slightly longer periods interrupted by brief wake periods, and, finally, by uninterrupted sleep.

The onset of sleep may last for a short period of one or two minutes, or for about half an hour.

Awakening is often introduced by a deep thoracic inspiration, which has the peculiar action that—as shown by Bolton, Charmichael, and Stürup—it elicits a vigorous vasoconstriction—*i.e.*, an increased sympathetic activity. The deep sigh with which we leave the pleasant dreamland in the morning to take the plunge into the difficulties of the day, is, therefore, in reality a most expedient mechanism, serving to remove the last remnant of the night's sleep preparedness.

But dangers threaten the weak person from early morning on. For awakening occurs instantaneously, in contradistinction to the onset of sleep, which is a more protracted process. If a subject yields to his disinclination to allow himself to be torn out of the arms of Morpheus, he will easily fall asleep again, and another onset-of-sleep period will set in, and sleep preparedness increase again. An additional morning slumber thus may only make one more sleepy. It is tempting, but serves no useful purpose.

If the registration of respirations is continued throughout the night, the peculiar phenomenon will be observed that deep and undisturbed sleep, with absolutely regular respiration, occurs only in periods of up to one hour, connected by episodes of irregular respiration, indicating light or interrupted sleep, which collectively extend over more than one-half of the night's sleep even in young, healthy experimental subjects, and regardless of whether they have a respiratory valve in the mouth or sleep quite untroubled.

Interrupted sleep manifests itself only in the respiration movements, belonging to the somatic nervous system. We are actually concerned here with a condition of partial wakefulness, as consciousness is not affected, for which reason the subject is unable himself to perceive it as such. In addition, it must be borne in mind that there is a considerable inclina-

tion to complete amnesia of brief wake periods occurring throughout the night, even if the subject has been fully conscious during these periods and has answered complicated questions. On the other hand, it has been established that brief periods of sleep may occur in a person who is otherwise awake, without his noticing it.

Some of the brief periods of sleep last for only a few seconds or less. Even in the shortest of these periods, a complete change of motor as well as of sensory functions appears, the reflex irritability is lowered, and the changes occur instantaneously, as can be read from the respiratory curve.

That the vegetative regulation is also active in such short periods of sleep, and not only in the more protracted diurnal rhythm, can be demonstrated by the simultaneous registration of respiration and the plethysmography of a finger. When one awakens with a deep thoracic inspiration, a hasty vasoconstriction sets in, indicating increased sympathetic activity. This is followed by a gradual dilatation of the arterioles and the arteriovenous anastomoses, indicating gradually decreasing sympathetic activity, and when the latter has reached a certain lower limit, sleep sets in again with instantaneous somatic functional changes.

So far we possess no definite knowledge about the neurophysiological mechanism underlying these sudden functional changes associated with the onset of sleep and awakening. But Bremer's interesting experiments suggest that a functional and reversible interruption of the centripetal pathways to the cortex occurs, in the vicinity of the thalamus. Some newer investigations of Magoun and co-workers seem to show that this "de-afferentation" takes place in the brain-stem reticular activating system. According to Magoun, "the presence of a steady background of . . . activity within this cephalically directed brain-stem system, contributed to either by liminal inflows from peripheral receptors or preserved intrinsically, may be an important factor contributing to the maintenance of the waking state, and . . . absence of such activity in it may predispose to sleep." This activating action of the reticular system may be conducted over "(1) a thalamic path involving transmission to the ventromedial part of the thalamus with relays to the cortex from the remainder of this structure; and (2) an extrathalamic path involving direct

passage into the internal capsule from the sub- and hypothalamus.”

We might theoretically imagine that a certain sympathetic activity is required for the action of the nervous cells—just as the sympatheticus upon the whole regulates the intensity of various functions by a tonicizing influence on the vaso-motors, the secretion of sweat, certain psychic functions, and so on. If the sympathetic activity goes down below a certain level, the connection between the nervous cells is discontinued, and this happens suddenly, according to the “all-or-none” law. When the sympathetic activity again rises above a certain level, conductivity may be reestablished.

I am not going to discuss in detail the principles underlying this theory. It is only to be taken as an attempt to provide a working hypothesis to be used in the further study of these fundamentally important problems. I only want to mention one experience that appears to support this view. All of you know that weak irritants with which a vigorous affect is connected will awaken a sleeping person far more easily than even vigorous irritants of an indifferent nature. This holds good for the mother who can sleep despite radio and other violent noise, but wakes up at the weakest whimper of her baby, or the skipper who wakes up when the wind shifts. In either case, the sound irritants, insignificant as they are in themselves, are of vital importance for the person concerned and coupled with a fear that something untoward is going to happen. Anxiety and other vigorous affects are accompanied by considerable sympathetic activity; hence irritants laden with affect are far more efficacious than others as wakening irritants.

There can hardly be any doubt that, as already mentioned, the brief periods of sleep are of far-reaching scientific significance—*e.g.*, to psychology, where states of distraction and flight of ideas may be caused by momentary interruptions of consciousness, undoubtedly of the same nature as those encountered in momentary periods of sleep. Clinically, also, however, we encounter states in which a closer study of this subject would no doubt prove fruitful, such as states of weariness, lassitude, narcotic intoxications, and certain psychoses.

Unfortunately, registration of the respiratory pressure is rather troublesome to deal with in practice. The mere fact

that the patient has to lie with a mouthpiece and a nosepiece excludes its employment in a considerable number of cases. Of greater practical significance is electroencephalography, although the information gained by this method about the very brief periods of sleep are not absolutely reliable and concise. On the other hand, however, the electroencephalographic studies of sleep have been of great significance, as they have given much interesting informations about normal and pathological sleep.

We will now have a look at dreams, on the basis of the conception of sleep function and sleep regulation I have mentioned. In my mention of the sleep center, I considered affect and sleep preparedness as the two extremes of the register on which the center plays, ranging from the highest to the lowest sympathetic activity.

First, however, we will want to have a look at the behavior of the psychic functions in general during the onset of sleep and during sleep.

When sleep preparedness becomes sufficiently pronounced, when the internal, vegetative sleep preparedness and the external conditions for sleep are present, when you are comfortably seated in an easychair or lying in your bed without disturbing factors, you become overwhelmed by a feeling of sleepiness and readily pass over into the very first stage of sleep: you doze.

While dozing, a subject is mainly awake. But the state of wakefulness is interrupted now and again by very short periods of sleep, lasting from only a fraction of a second. These brief interruptions, however, are sufficient to give the state a mark of its own. It is not possible to follow a definite train of ideas; thoughts become fugitive and incoherent, with loose associations, without concentration, and, as a rule, also without inhibitions. The mental activity suggests dreams rather than the ordinary thoughts of the wakeful state; it is a kind of daydreaming. Gradually as the periods of sleep increase in length, the dreamlike character becomes more pronounced, as the control of consciousness disappears. For years, discussions have been going on as to whether a subject always dreams during sleep, during lighter and deep sleep alike, or whether he dreams only during lighter sleep. Such discussions are of little value, however, if they are not sup-

ported by analyses in which subjective statements about the possible occurrence of dreams can be correlated with objective criteria of sleep, as by electroencephalography. Such analyses seem to show that dreams appear only during lighter—i.e., interrupted—sleep, deep, uninterrupted sleep being always dreamless.

Before attempting to form an impression of the contents and character of dreams, we shall have to look at the behavior of certain psychic functions during sleep.

Special examinations have established that the different psychic functions are not affected in the same way during the onset of sleep, with its changing phases of wakeful and sleeping states. As a whole, the most highly developed mental functions are the first to fall asleep and the last to wake up, while the more primitive ones are the last to sleep and sleep the shortest time.

Consciousness itself, the clear recognition and control of both internal and external experiences, is the first to be affected. Even after the first, fairly well pronounced spell of sleep of a couple of seconds' duration, the subject loses consciousness to such an extent that he has no longer any clear recognition of his state or of his experiences—assuming, naturally, that the onset of sleep takes place in the normal manner, uninterrupted by intervals of complete awakening. From this juncture, a subject loses the capacity of recognizing that for some time he has been oscillating between sleep and a state of partial wakefulness. This is why it is so difficult to obtain reliable information as to what is really happening in one's self in this peculiar state on the borderland of sleep.

The capacity to perform spontaneous acts is retained somewhat longer than consciousness. From experiments with simultaneous registration of a single spontaneous act and a respiratory curve, it will be seen that, true enough, the voluntary act is interrupted by the earliest periods of sleep, but it returns in the first few intervening periods of wakefulness. Only when the sleep periods get the upper hand does the voluntary activity cease.

One of the most primitive mental functions—the capacity to react or to perform a single movement in response to an order—is the one retained the longest. The ability to react is retained in all periods of wakefulness, even in the last,

brief ones, surrounded by fairly long periods of sleep immediately before the onset of deep sleep; whereas it disappears or decreases considerably in all periods of sleep.

During interrupted sleep, with alternating periods of wakefulness and sleep, there are, moreover, as demonstrated by the experiment with the plethysmograph, considerable variations in the sympathetic activity, which increases in periods of wakefulness, where there is a possibility of emotional mental activity if the subject is awake, or of dreams if he finds himself in what we call a state of partial wakefulness without control of consciousness. In the intervening sleep periods, a reduced activity of the sympatheticus or relatively increased sleep preparedness is present.

- Upon the whole, the contrast between affect and sleep preparedness plays a very great rôle in sleep as well as in the higher mental functions during sleep, especially dreams. A lasting affective tonus may compromise sleep, whether it be due to joy, excitation, or brisk mental activity, or has been produced by grief, worry, depression, annoyance, or fear. It will flatten sleep, shorten or entirely prevent the periods of restful, deep sleep, and promote lighter sleep—*i.e.*, the interrupted sleep in which dreams occur, at any rate primarily. The predominant affect at the junctive concerned, moreover, may have an influence on the contents of the dream, depending on its special character. Bearing in mind the behavior otherwise of the mental functions during such interrupted sleep, remembering that the control of conscious recognition and the inhibitions are entirely abolished and that mental activity and capacity for reaction are present in brief, constantly interrupted periods, we shall be able to form some idea of the character of the dreams, and we can understand that they will have to be fugitive, often disconnected, often highly emotional, either pleasant, such as the so-called wishful dreams, or unpleasant, such as nightmares of various kinds.

The contents of dreams have always commanded the greatest interest. In the Middle Ages dreams were interpreted and expounded as auguries, with the application of a good deal of mysticism—just like other forms of magic and sorcery. Only in the last hundred years has the study of dreams entered more exact scientific tracks; and the Freudian school especially has made an important contribution to the understanding

of dreams through a series of excellent observations. Freud emphasizes that the contents of dreams are derived from unconscious mental material, organically conditioned instincts and impulses, repressed memories, complexes, and wishes, especially from childhood, and sexual instincts, which in the wakeful state are shut out from consciousness by a censorship created by moral and social considerations and conventions.

This conception is in keeping with the impression of the character of dreams obtained from the above mentioned studies, according to which we might expect, on the basis of the abolished conscious recognition and control, that more primitive memories, feelings, and instincts would dominate the contents of the dreams.

II. SLEEP DISTURBANCES.

In various morbid conditions affecting the sleep center in the hypothalamus and its activity in one way or another, highly varied disturbances of sleep may develop. The best known, and the most frequent of them, is sleeplessness. Less well known, but equally significant, are conditions that manifest themselves in too much sleep, either permanently or in sporadic attacks, and affections in which a disunion of the sleep function occurs.

Disturbances of sleep may be divided into three groups: (1) sleep disturbances that attack the sleep-regulating center in the hypothalamus; (2) disturbances of the interplay of the sleep center and the other parts of the brain; and (3) disturbances of sleep caused by irritants within the organism or by the outer world.

1. Among affections in the first group is *epidemic encephalitis*, first described by Professor Economo of Vienna. It occurred in great epidemics in the years immediately after World War I, and among its most conspicuous symptoms during the acute stage is a sleeping state, often lasting for several weeks, from which, true enough, the patients can be roused and kept awake for shorter periods, but into which they will again relapse when left undisturbed.

In this disease, and particularly in its sub-chronic stage, states with the reverse sleep rhythm may occur, in which the patients sleep in the daytime and are harassed by sleeplessness and unrest at night. In other cases the disease passes into a

chronic stage, in which there may be lengthy periods of time, often lasting several years, during which the patients cannot sleep at all—the most pronounced cases of sleeplessness known.

Cerebral tumors in the vicinity of the hypothalamus may give rise to disturbances of sleep in certain stages of their development, occasionally with sleep states in sporadic attacks or of longer duration, which, if the growth of the tumor continues, gradually will pass into complete unconsciousness before death eventually occurs, unless the patient is operated upon in time.

Narcolepsy is an affection of the hypothalamus, due either to encephalitis, tumor, or traumatic injuries, to inheritance, or, most often, to no demonstrable cause; it manifests itself by attacks of sleep. Whether walking, standing, or sitting, the patient is overcome by a sudden and irresistible inclination to sleep, often falling asleep quite literally and sleeping for some minutes. He wakes of his own accord, and between attacks is usually normal psychically in every respect. The attacks may appear several times in a day, and, of course, they inconvenience the patient as well as involving a direct danger for him.

There is good reason to draw attention to this affection, because laymen often take it to be "a bad habit" or a peculiarity in the person concerned. As, moreover, it is possible to keep the disease entirely in check by suitable doses of benzedrine, there is every reason for patients suffering from the condition to seek medical advice, and for the doctor to institute treatment, which during the first twelvemonth will have to be continually controlled and often modified. Subsequently treatment will have to be maintained, often throughout life, since the treatment involved is a substitution therapy, and not a symptomatic treatment. It should furthermore be stressed that benzedrine will have to be administered in sufficiently large doses, from one tablet of 5 milligrams three time a day, to two to three tablets five to six times a day.

Narcoleptics with many attacks in a day sleep poorly at night, and a number of them, in addition to the attacks of sleep, suffer from so-called *cataleptic attacks*, in which the patient suddenly feels flabby in all his muscles, falls to the ground "like a dishrag," and is unable to move for some

seconds. During attacks the patient is fully conscious and can perceive everything going on around him; but he cannot react in the slightest. These attacks usually appear in connection with emotional affect—e.g., laughter—so that the patient almost literally is doubled up with laughter, and they must be looked upon as a kind of partial sleep, during which only the muscles are asleep while all other parts of the organism are awake.

Again, a number of cases occur in which it is not possible to demonstrate any definite affection of the sleep center, but in which the sleep center, or at any rate the sleep-regulation process, does not function properly. When a person turns in his sleep, this always happens during interrupted sleep and hence in a partly wakeful state, and there is nothing abnormal about it. But both talking and walking in one's sleep must be characterized as abnormal when these phenomena occur to any marked extent, and they are often symptoms of an illness that may call for medical treatment. If a person is very tired, similar phenomena may appear. Thus exhausted soldiers who have been marching for a long time may march on while they are asleep, and the tired pianist in a restaurant may fall sleep at the piano, and yet go on pounding on the keys.

Various of the vegetative functions which normally undergo considerable variations during sleep may behave in a less satisfactory way in the presence of morbid conditions. Nocturnal enuresis, especially in children, is a frequent feature. It may be ascribed to widely different causes: lack of upbringing, unfortunate conditions in the home, nervousness, and various diseases—e.g., adenoids.

Nocturnal enuresis can always be referred to poor sleep regulation; often it is due simply to the fact that the child sleeps too heavily. Such children can be treated with benzedrine, which reduces the depth of sleep, combined with psychotherapy to train the necessary conditioned reflexes. The child should, however, always first be subjected to a careful neurologic-psychiatric examination.

In elderly people the sleep-regulation function is often weakened, with the result that sleep becomes light and of short duration. It is as if the sleep center loses its elasticity; it can no more relax so as to give sleep the necessary depth

and duration. Furthermore, the excretion of urine is not sufficiently reduced and the bladder wall not sufficiently relaxed, and old people are further inconvenienced by a desire to make water, often several times in the course of a night.

Finally, it should be mentioned that in people on shiftwork, who work alternately during the day and at night and hence have to sleep at different times, the sleep function is often considerably impaired. As already mentioned, the sleep center is adjusted to a certain diurnal rhythm. Sleep preparedness makes its appearance at the usual time and in some cases refuses to be called into action at unusual hours of the day. Therefore, such people cannot sleep in the daytime, however quiet their environment. Later, such attempts to alter the normal diurnal rhythm and sleeping time may result in such impairment of the sleep-regulation function that sleep becomes impossible even at night. This applies especially to elderly people.

People who work regularly in the daytime also may abuse their sleeping habits and in consequence come to be bad sleepers. People who usually go to bed at 10 o'clock, but occasionally, after having been to a party, do not go until 1 or 2 o'clock, need not always blame the food or the cigar because they cannot fall asleep at this unusual hour. They have simply passed the juncture when they usually have their deepest and best sleep, and get to bed at an hour when sleep is normally interrupted and light. Because their sleep curve is the same night after night, and because, moreover, they may be a little excited after a pleasant party, it is but natural that sleep is some time in coming.

2. *Disturbances of the interplay of the sleep center and the other parts of the brain* are responsible for by far the great majority of cases of sleeplessness. The mildest cases may occur in normal subjects on whose brain action unusually heavy claims are made at certain times by forced work, speculations, worries, grief, anxiety, joy, or other emotional affects. All these states, as we have pointed out, set going an increased sympathetic activity which makes it impossible for the hypothalamic center to relax, with the result that sleep will not come.

A strikingly large number of cases of sleeplessness, often of long duration, must be ascribed to one isolated cause—the fear of sleeplessness. Sleeplessness may develop from some

adventitious cause, which in itself results in only one or two sleepless nights, but these appear to the subject to be so dreadful that he looks to the coming nights with the greatest concern and anxiety: "Supposing I cannot sleep. I'll never fall asleep. It is dreadful." He works himself up on account of a lot of other things after he has gone to bed. And the fear dispels any possibility of sleep.

Nervous people very often suffer from sleeplessness during long periods of their lives. Upon the whole these people have a poorly regulated vegetative nervous system, and for this reason easily get headaches, "nervous" cardiac and digestive troubles, and many other complaints. Again, their mental state readily gets out of balance, so that they become diffident, excited, depressed, or elated, or, briefly, they readily develop strong emotional affects and changing emotional states which influence their sleep centers, delicate as they are, and sleeplessness results.

In the mental diseases proper, we encounter the same phenomena, only here they are considerably intensified; sleeplessness is in fact a prominent symptom in most mental diseases. In the manic-depressive group, not only may the strong mood swings in a manic or depressive direction in themselves bring about sleeplessness, but the usual phenomena that accompany this mental disorder—in manic phases overactivity, increased energy, and an active initiative in many peculiar directions; and in depressive phases, delusions and occasionally hallucinations with accompanying strong emotional affects—also result in sleeplessness produced by the mechanism already described. In less pronounced depressions, sleep may, however, be excellent.

In the other large group of mental disorders, the schizophrenias (dementia praecox), sleeplessness is also a frequent symptom. In certain forms (the catatonic types) a particularly well-developed sleep preparedness may occur, the skin temperature being low in the daytime and rising abruptly in the evening to a high level during the night (Kirk). These patients sleep well at night. But others are affected with such pronounced paranoid ideas, hallucinations, strong emotional tensions, or phases of restlessness that they can be quieted only by large doses of soporifics. Sleeplessness in these cases may be extremely refractory and prolonged.

Mental disorders arising as a reaction to psychic influences also are often accompanied by sleeplessness, which, depending on the type of manifestation of the disease, is produced by mechanisms similar to those described. It may, however, be mentioned that in certain hysterical mental disorders, fairly protracted sleeplike states may occur, but they are not nearly so frequent as sleeplessness.

A number of mental disorders owe their development to chronic intoxications, resulting in injuries to the cerebral tissue. These injuries may also involve the sleep center—as, e.g., in chronic alcoholism. Delirium tremens, the dramatic acute, alcoholic intoxication in chronic alcoholics—which, before alcohol was made taxable in Denmark, was of frequent occurrence and still is seen occasionally—thus brings about a state of violent restlessness, with grotesque hallucinations and complete sleeplessness, which requires large doses of diethyl veronal (barbital). Also, less dramatic forms of chronic alcoholism are accompanied by sleeplessness.

Alcohol has a poisonous effect on the nerve cells, the metabolism of which is destroyed, leading to a deficiency of vitamin B 1. The ingestion of large doses of vitamin B 1, therefore, often has an excellent effect, especially in delirium. Also in certain cases of sleeplessness due to causes other than alcoholic abuse, the ingestion of vitamin B may have a favorable effect.

The abuse of various drugs—morphine, cocaine, sleeping drafts, and benzedrine—may, through different mechanisms, lead to sleeplessness. Benzedrine has a direct sleep-preventing effect; the others prevent sleep only when, after they have been used for some time, a habit has been formed, with the increasing craving for the drug.

3. The third group of sleep disturbances includes those due to endogenous and exogenous irritants. A few of these border upon the disturbances I have just mentioned in the second group. In various diseases caused by infection, the rise in temperature is often induced by a state of irritation in the organism, which affects especially the nervous system and produces sleeplessness. On the other hand, during protracted fever, an increased inclination to sleep is often present, and the patient lies dozing.

Many patients with heart trouble and respiratory difficulties sleep very badly at night. Their respiratory difficulties

are increased when they are in bed, and when the sensitivity of the respiratory center is lowered at the onset of sleep, the condition often becomes simply unbearable. Some of these patients get unpleasant fits of asphyxiation the moment they are about to fall asleep, and others never have a really deep and undisturbed night's sleep, because their respiration constantly places obstacles in the way. They can at the best obtain sleep during the half minute when respiration is suspended in breathing of the Cheyne-Stokes type, being awake the next half minute, when respiration is vigorous. These poor people, therefore, never get the rest they so badly need.

All forms of intensive and protracted pain, regardless of their location, have an adverse influence on sleep. They may create a constant nervous state of irritation, preventing relaxation of the sleep center and the onset of sleep; and pain that occurs in attacks, or which is increased by movements, may cause constant interruptions of the sleep when it has at long last made its appearance.

Sleep, however, requires not only that body and soul be at rest before it can fulfill its mission; it also makes certain demands on the surroundings. Any stimulus from the outer world acting on one of our senses may disturb sleep, whether it be light, sounds, touches, changes in temperature, or other stimuli. It is worth noticing, however, that human adaptability is very great, in the matter of sleep as well as in other fields. Hence the stimuli that disturb sleep are primarily unfamiliar ones.

Treatment of Sleeplessness.—Treatment of sleeplessness often is a difficult task, calling for considerable personal effort on the part of the physician. It must be remembered that *sleeplessness is never a disease per se; sleeplessness is always a symptom*. And often it is not a single disease that produces this symptom—it appears as a consequence of several afflictions or other unfortunate factors that jointly bring about an often refractory sleeplessness. The underlying factors in many cases are disclosed only after very thorough and extensive investigations on the part of the doctor. I so strongly emphasize this point because at first sight sleeplessness often may give the impression of being a detached affection, of being the patient's only complaint. But do not allow yourself

to be confused by this; a great many accompanying factors will always come to light.

Before setting to work to treat a case of sleeplessness, the doctor will have to make a somatic and a mental or psychiatric, as well as a social, diagnosis for the patient; and when this has been done, it is not enough that he prescribe, quite routinely, some sleeping draft.

The treatment of sleeplessness consists of three different phases, all of them equally important. They are (1) the hygiene of sleep or environmental treatment; (2) the symptomatic treatment; and (3) the causal treatment.

1. *As regards the hygiene of sleep or environmental treatment*, it is important that the doctor fully inform himself about the conditions under which the patient is living—his work, his dwelling, his family life, and his whole mode of living. This orientation will often bring to light information about conditions that are so flagrantly at variance with the simplest possibilities for getting proper sleep that merely the most necessary information and rational guidance may be of great significance therapeutically.

It is often very helpful to give the patient thorough instruction in the physiology of sleep and general hygiene, and since delivering a long lecture on these subjects to each patient may be too troublesome and time-consuming, I have found it of value to collect all the necessary information in a booklet entitled *Sleep and Sleep Disturbances*. The doctor may recommend to the patient to go home and study this booklet, and then return. The doctor can now really set to work to get to the bottom of the patient's problems, with the active coöperation of the patient. Numerous colleagues have used this method of establishing therapeutic coöperation with their patients, and as far as I know, they have been satisfied with the results.

Unfortunately time does not allow me to go into details respecting the different aspects of the hygiene of sleep. Throughout the day it comprises a large number of little considerations that can be partly deduced from what I have said about the physiology of sleep, and from many age-old home remedies which the modern physiological conception of sleep has partly confirmed and restored to credit again. Thus it may be mentioned that *light meals stimulate sleep prepared-*

ness without interfering with sleep, as meals that are too substantial of course may do. Anyhow, we know that a *light, late supper* just before going to bed, a glass of beer or wine, may be an excellent soporific for many people.

Furthermore, a suitable arrangement of the bedroom, with a certain amount of fresh—but not cold—air, darkness, quiet, a bed with not too light and not too heavy bedclothes to cover the sleeper, and the introduction of a peaceful, regular regimen and plan for the evening hour, will work wonders in certain cases. In this connection I shall have to call to mind Pavlov's important studies on the conditioned reflexes and the view he takes of sleep as an internal inhibition of conditioned reflexes. Even if Pavlov's theory does not cover more than one aspect of the problem, there is no doubt, that this aspect is of the very-greatest significance in numerous of the phenomena of everyday life, not least in sleep. *Practicing a special ceremonial for the last hour before going to bed* and adhering strictly to this ceremonial every night is, therefore, of the greatest significance for many people's sleep. This holds true not least for children, whose sleep involves special problems, dealing with which would also take us too far.

2. *The symptomatic treatment of sleeplessness* consists essentially of the administration of medicaments, and it holds true of this treatment that, rarely as it will have a favorable outcome when used as the only measure, it is indispensable as a link in the treatment. Unfortunately, treatment of the causes of sleeplessness usually takes time, and since it is of the greatest importance, not least while treatment is in progress, that the patient should sleep well, a temporary medicinal treatment will have to be instituted simultaneously, under constant medical supervision and with gradually decreasing doses, so that eventually, when the final result of the causal treatment is seen, the medicament can be withdrawn.

The medicinal treatment comprises treatment partly with sleep-inducing drugs proper (hypnotics), partly with sedatives. Of the hypnotics, the doctor should routinely use a small group, consisting of a few preparations of different strengths, ranging from very mild, quickly secreted drugs to more powerful ones with a protracted effect. And to these preparations the doctor should adhere, without too many side glances at new, special preparations puffed by advertisements

in the press; these should be included in the stock preparations only after careful deliberation. The nature of the sleep disorder naturally determines which remedy will have to be applied in the particular case, whether the trouble be difficulty in falling asleep, restless, interrupted sleep, or too early awaking. Hypnotics should be prescribed only in small quantities at a time—with due regard to the lethal dose. The patient should be seen frequently while using the drug, so as to enable the doctor to change the dose and, if necessary, also the remedy. When medication is discontinued, the doctor must make sure that the patient has not accumulated a large stock of tablets.

In a strikingly large number of cases, however, a hypnotic proper is less important than *treatment with a suitable sedative*. Many Danish physicians tend to disregard this point. A sleep disturbance, as is well known, usually is but a link in a more generalized irritative state of the nervous system, *a hyperirritability toward all occurrences of the day*, which it is our object to combat. But in this field, too, it is necessary to adapt one's treatment to suit the individual patient. Phenobarbital is fine, and in certain cases it is unequaled as a sedative, but only in very exceptional cases is it a satisfactory hypnotic, and even as a sedative it may have unfavorable side effects in many patients, such as an increased feeling of tiredness, impaired memory, decreased capacity for concentration and initiative—to some people very unpleasant effects, even though other patients may consider them desirable.

I will, therefore, strike a blow for the composite sedative, prescribed to suit the requirement of the individual patient. With a suitable composition, an intensified effect of the individual substances is obtained, while at the same time undesired side effects may be reduced to a minimum. In this case, too, the doctor should have certain stock drugs on which to draw—*e.g.*, phenobarbital, codein, belladonna, and analgetics, such as antipyrine and phenacetin. They may be made up in individual combinations, and a laxative should often be added, supplemented by a flavoring agent or a suitable tonic. This may sound complicated, but once it has become the routine, it is most effective.

I want, however, to recommend once more that the dose be carefully supervised and adjusted. As a rule, tolerance of

the drug changes a little within the first fortnight, after which an adjustment of the dose will be necessary. It is of course often difficult to find the absolutely right sedative for the individual patient, and occasionally a change to quite another drug will be necessary after the first experiment.

To mention a few general rules for the selection of sedatives, sedatives proper—*e.g.*, phenobarbital—are to be preferred in neuro-vegetative irritatory conditions, whereas their effect is less satisfactory in depressive conditions, because they may aggravate the inhibition and the feeling of tiredness which may be a prominent, if not the predominant, symptom, even in cases of milder depression. Sodium amyital often has a very favorable effect in cases of this kind. As instances of excellent composite sedatives, the Swiss preparations, Bellegal and Belladetal, may be mentioned.

In suitable cases of more or less masked depression, with marked difficulties in sleeping, electric shocks may be an excellent form of therapy. In some cases only one or a few shocks are required.

3. *The causal treatment of sleeplessness* naturally comprises treatment of any physical or psychic disease that may be present. I will only pass lightly over bodily therapy, mentioning those cases in which various *conditions of pain* are responsible for the sleeplessness. In these cases even the most powerful hypnotics are of no use if employed alone. They will not make the patient sleep, or, at best, the patient will constantly be awakened by his pain. Treatment will primarily have to be directed against the pain, either in the form of local treatment or by means of analgetics. In acute transient conditions of pain, the doctor should not use morphine preparations too sparingly. These preparations are perhaps the only ones that can relieve the patient of pain, so that he may sleep.

But it should be emphasized that in practically all cases other than those in which the patient is in pain, morphine is a miserable soporific which should not be used.

Treatment of the various forms of psychosis proper also I shall not deal with here. In most cases it is decidedly the business of a specialist. But I do want to mention treatment of the conditions that, in the doctor's practice, are responsible for the greatest number of cases of sleeplessness: the *psycho-*

neuro-vegetative states of restlessness or irritation. These conditions naturally include a large number of different conditions, ranging from constitutional conditions to athymic and catathymic neurotic conditions—i.e., nervous conditions induced by physical, external, or mental causes. As causes of sleeplessness, however, they have so many features in common that in certain respects we are justified in dealing with them as one.

Among these common features the most important are a neuromuscular state of tension or strain, and a kind of profusion of confused thoughts centering around pathogenic or highly emotional subjects to an extent that they are beyond the control of the patient. These symptoms may recede into the background when the patient is kept busy throughout the day; still, they are there all along, influencing his whole conduct and his reactions, and they become particularly prominent when he gets to bed and is trying to fall asleep. The thoughts then tear around in his head; he tosses on his bed, restless and strained. The reason why the condition becomes so particularly unbearable before the onset of sleep is not only the lack of occupation and other possibilities of a neutral diversion of the mind, but also the physiologic hypnagogic reduction of the capacity for concentration, which must be ascribed to the occasional occurrence of momentary sleep periods.

You are no doubt all of you familiar with this unpleasant state experienced on evenings when it was not possible for you to fall asleep, either because you were absorbed by an interesting problem or because you were overtired. And you will, therefore, understand how dreadful it must be for neurotics and others, when this experience is repeated night after night, month after month, with unbearable intensiveness. You will also understand that these unhappy patients need your help, even though this help places the heaviest demands on your skill and patience.

In many patients a further factor has to be taken into account—the fear of sleeplessness. It may often increase to a state of panic, and then sleep of course stays away altogether.

These three symptoms—the neuromuscular tension, profusion of confused thoughts, and anxiety—all institute a considerable sympathetic activity, which prevents sleep preparedness from being established, and sleep fails to appear.

The isolated symptom of flight of ideas at the onset of sleep may be managed by instructing the patient to imagine a beautiful, restful landscape in summer, with which he is familiar. He is then to go through all the details of the picture and at last concentrate his "field of vision" on a small part of it which he is to attempt to retain. If extraneous thoughts interfere—and they always do, to begin with—he will have to start all over again, taking the same picture and concentrating on the same point. In the course of time many patients manage to carry through the exercise; the interfering emotional thoughts are kept away; and the patient falls asleep. This method is superior to counting sheep, whether backwards or forwards, for in doing that it is possible to be concerned with other thoughts, and then the whole procedure is in vain.

If a neuromuscular tension is coexistent, this method will hardly be of any use. In such cases it is suggested that *relaxing exercises* be instituted. An excellent method, which the patient can practice himself, has been indicated by Fink in his *Release of Nervous Tension*. He explains in detail how the patient should lie down on his bed on his back, place a cushion under the back of his neck, one under each forearm, and one under the knees. In this posture all the muscles can be relaxed, and the patient should talk to his muscles, according to a certain plan, telling them "to relax" with each expiration. He has to take one group of muscles at a time, concentrating his whole attention on the sensations arising in it—slight paresthesias, and a sensation of gravitation and heat.

Fink's book contains a detailed description of relaxing exercises, intended for home study—that is, under regular medical supervision and guidance. The exercises will have to be done for half an hour twice daily, one course of exercises just before going to sleep. In favorable cases, when the patient has learned to master the exercises, he will fall asleep while doing them. In other cases—e.g., if he cannot sleep on his back—he will attain complete relaxation in the dorsal posture, then push away the cushions, turn over on his side, regain relaxation in this posture, and fall asleep.

Suitable treatment with sedatives may be of great assistance in promoting the relaxing exercises.

There is no denying that these exercises put certain demands on the patient. They require a certain amount of intelligence,

maturity, will power, and perseverance, if the patient is to derive any real benefit. Fink recommends his method as a means of learning "self-control through nerve control," but the method is valid only if certain conditions are fulfilled. If the patients do not possess the psychic qualities mentioned to a sufficient degree, or if their neurosis is severer, and, especially, if the emotional aspect of it is very pronounced, the method will often fail.

The physician will then have to step in to promote the relaxing mechanism. This may be effected partly by means of Schultz's "*autogene Training*," in which the patient is trained at the doctor's office, after which he may continue the exercise in his own home, partly by direct hypnosis. During hypnosis the patient is easily taught relaxation, and he may be made to recognize the sensations brought about by relaxation. Furthermore, with the aid of post-hypnotic suggestions it is possible to promote the patient's own attempts to relax as well as to impart to him a sensation of sleepiness at the suitable junctures. The most valuable effect of hypnosis in many cases is, however, a general soothing and sedative influence.

The above-mentioned forms of therapy are, however, applicable only in those cases in which the cause of the neurosis has been fully cleared up, and in which any underlying conflicts have been removed in one way or another. But it is often difficult to determine to what extent the causal factors have been removed, as emotional conflicts may have several causes, some of which may date years back and be forgotten or repressed. In such cases a deep psychiatric exploration is required, or, in certain cases, psychoanalysis proper, before it is possible to institute a treatment that is really effective in removing the causal factor of the condition—including the sleeplessness that was our starting point, but that has perhaps in the course of time proved to be only one symptom of a complicated mental condition.

Such complicated cases will usually have to be referred to a specialist for treatment, and even a specialist may find them difficult to manage.

Respecting treatment, the situation in most countries is the more difficult because the number of psychiatrists who are fully conversant with the necessary psychotherapeutic methods

is so pitifully small. Most psychiatrists are kept far too busy by their hospitals and heavy administrative tasks. I am not exaggerating in saying that just now psychiatry is the branch of medicine that is in the greatest need of recruitment. We need the services of many, many more psychiatrists. Psychiatry—not the old, isolated type as we know it at the older mental hospitals, but the whole modern psychopathology—is advancing by leaps and bounds, a development for which the two World Wars are largely responsible, not least in England and America. The time when the diagnosis of diseases could be made in a laboratory, and when the patients were merely cases, presenting such and such positive and negative reactions, will soon be a thing of the past. It is now being realized once more that patients are human beings as well, and that psychopathologic factors play a very significant part even in diseases that have been considered up till now as of a purely physical character, such as ulcers of the stomach and asthma.

We have not achieved our purpose, however, merely because psychiatry has undergone the requisite development as to intensiveness and extensiveness. It is necessary that all physicians realize the significance of the psychopathologic elements that may be present in the various diseases. They will have to know also which diseases require the special assistance of a psychiatrist—when some time in the future this assistance is adequately available. But, above all, the physicians must themselves be so well versed in psychopathologic methods that the necessary psychiatric diagnostics and psychotherapy form part of their own treatments. This objective is not so far distant as might be believed, psychotherapy having at all times been an essential factor in all fine medical art. What is lacking, is, I believe, rather a greater systematology in our knowledge of these domains.

These observations especially apply to the treatment of sleeplessness, for even if more complicated cases, requiring treatment by a specialist, do occur, the main rule must always be that the patients be treated in their own environment and by their own physician.

BOOK REVIEWS

THE PSYCHOLOGY OF ADOLESCENT DEVELOPMENT. By Raymond G. Kuhlen. New York: Harper and Brothers, 1952. 675 p.

One of the most important aspects of Dr. Kuhlen's new college textbook, *The Psychology of Adolescent Development*, is the emphasis he places on the fact that "adolescence has been a highly overdramatized phase of development, that it is not usually stressful, that it is characterized not so much by a distinctive 'psychology' (indeed, the same developmental and psychological principles apply in this life phase as elsewhere) as by a group of developmental problems, biological and social in origin, which typically, but not necessarily, occur during the second decade of life."

This is in line with modern trends of thought, based on evidence provided by modern psychological research and studies of primitive peoples, especially the work of the anthropologist, Margaret Mead. While this point of view is not new—going back to the pioneer work in the field of adolescence by the late Leta S. Hollingworth, of Teachers College, Columbia University, who emphasized the fact that the so-called "storm and stress" period of adolescence does not come from the physical and glandular changes that occur at this time, but rather from environmental conditions—it is a point of view that is widely held by all who work in this area of development.

Furthermore, Kuhlen has taken the position that the characteristic development and the adjustment problems of adolescence can best be understood if they are examined from the angle of biological change in a cultural context, with emphasis on the developmental trends that characterize childhood and, whenever possible, on the developmental trends of adult life. With this point of view, Kuhlen has organized his book to give students information on the physical, intellectual, and cultural background of adolescent behavior.

Slightly over one-third of the book is devoted to this task, with major emphasis on the physical growth and health of adolescents, the growth of mental capacities, and the impact of American culture on the adolescent personality pattern. The changes in behavior that occur during adolescence, as revealed in interest patterns—with emphasis on age and sex trends in these interests, as well as the factors that influence these interests—constitute the major subject matter of Part I of this text.

Part II is devoted to areas of adolescent adjustment. As an introduction, the student is acquainted with the typical motives and needs of the adolescent, the common frustrating conditions of our modern

culture, the problems arising from these frustrations, and an analysis of what constitutes good adjustment. Following this introduction are chapters devoted to analyses of adjustments in various areas of life: *social adjustment*, including adjustment to members of the opposite sex; *adjustment to organized society*, with a detailed treatment of moral attitudes and behavior, religious attitudes, and a philosophy of life, and the difficulties in this area of adjustment as manifested in juvenile delinquency; *adjustment to school*, including adjustments to teachers and subject matter; *development of vocational plans* and work experience; and *home adjustments*, with a detailed analysis of the methods of emancipation from parents.

Part III of the book, which consists of only one chapter, presents a pattern for the study of an individual adolescent. This is designed for the use of students for whom such a study constitutes a required part of the course in adolescent psychology. The techniques of interviewing and observation, standardized tests for studying adolescents, evaluations by peers, and other sources of information concerning the adolescent are described in detail. This should prove to be as useful to the instructor as to the student and should serve as a basis for a meaningful supplement to a course that is generally presented as a lecture course, with few opportunities for the student to familiarize himself with a real adolescent or with the techniques that are commonly employed in research studies.

The material of this book is presented in a manner calculated to appeal both to students and to teachers. At the end of each chapter is a brief, but all-inclusive summary of the high points of the chapter. This should serve as an excellent indicator of the important points of the subject matter, and should prove to be especially useful to students, who sometimes find it difficult to separate the important from the less important material when many experimental studies are used as the basis for the major part of the discussion. Then, too, there is a complete bibliography at the end of each chapter for the use both of students and of teachers. From this, a student may obtain the necessary guides for further research in areas of his interest as may the teacher who is not too familiar with modern research studies in this field.

Throughout the book, case histories are given as illustrative material. These should not only be interesting to the student, but should also show how behavior in the adolescent period is related to home, school, social, and general cultural factors. This type of illustrative material not only serves to lighten what otherwise would be very heavy reading for students, but it also acts as a guide to help them in any case histories they may make from their observational studies of real adolescents. In many respects, such material illustrates points

of importance in the text that are generally illustrated by tables, charts, and graphs. Kuhlen has not, however, sacrificed such illustrative material. Throughout the book, each chapter is generously illustrated with tables and charts of all sorts from the experimental literature.

In his preface, Kuhlen states his hope that this book will meet the needs of a "typical class" in adolescent psychology. Psychology majors, through the reports of experimental studies and the extensive bibliographies, are provided with a framework for viewing adolescent development through the eyes of the research worker. For students whose interest is primarily a practical understanding of adolescent development, there is the factual basis, well illustrated with case histories. Thus, both types of student are served within the scope of the same book.

And, for both, there is the important emphasis on the fact that adolescence is not a period of life separate and distinct from the rest of the life pattern, nor is it a time when physical changes alone are responsible for the behavior characteristically associated with adolescence. At the completion of their study of a course in adolescence, students will hold the view that the American adolescent is what he is because both of his hereditary endowment and of the type of culture in which he grew up.

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UNDERSTANDING YOUR SON'S ADOLESCENCE. By J. Roswell Gallagher, M.D. Boston: Little, Brown, and Company, 1951. 212 p.

This excellent book presents an enlightened psychiatric approach to the problems that parents and teachers encounter in dealing with adolescent boys. Dr. Gallagher has had wide experience among adolescents, having been both at Hill School and at Phillips Academy. His years in the academic setting have familiarized him not only with the needs and problems of the adolescent boy, but also with the commonest errors, misunderstandings, and anxieties of parents and teachers.

In the first chapter Dr. Gallagher discusses the need of adolescents to be independent, successful, and free, on the one hand, while hanging on to their families and childhood security on the other. He deals with the problems created by daydreaming, and the reasons for excessive absent-mindedness. He points out the value of fantasy in determining constructive future action. His chapter on health leads one to believe that he has had unhappy experiences with many hypo-

chondriacal parents and children. I agree with his generally sensible attitude that less medication (and especially glandular medication) is much better than too much. Psychosomatic medicine has created a desirable swing away from casual prescriptions.

He deals with the problems of adolescent sexuality calmly and with confidence, again indicating that anxious parents create many of the problems from which their children suffer. I feel that the same is true of rigid teachers.

His chapters on mental health for adolescents are reasonable and useful and he states in a comprehensible way, with case illustrations, many of the reasons for misbehavior and delinquency. The importance of helping the adolescent accept responsibility for self-government and for community spirit is underscored. This is part of democratic education as well as individual character-building. He understands the importance of helping youngsters develop strong personality traits, and of agencies that are designed to further citizenship and character formation.

In summary, this is a reasonable and useful book. It should prove the basis for discussion among parents of adolescent children and as required reading for P.T.A.'s and mother's clubs. The Mental Health Association of St. Louis uses it as reference material in study groups relating to adolescence.

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UNDERSTANDING YOUR CHILD. By James L. Hymes, Jr. New York: Prentice-Hall, 1952. 188 p.

In this book Dr. Hymes, who is professor of education at a teachers' college, and who has three children of his own, makes an impassioned plea to parents and teachers to use wisely their authority with children. For the alert parent and teacher the lesson that he propounds is not entirely new, but it is one that will bear repetition, particularly when it is conveyed in a style so simple and straightforward, and born of such deep conviction as to have the quality of prayer. For Dr. Hymes, while expounding many a psychological principle, never uses a technically psychological term, and while touching on considerable psychoanalytic theory, never mentions psychoanalysis.

The burden of his message is that children are continually striving to be worthy and acceptable, that they feel deeply, and the only way we can understand their feelings is to learn to interpret their overt behavior. The job of interpreting can be most effectively carried out

when we accord children the common decency and respect to which any human being is entitled, since they are then put at their ease and made free and uninhibited.

To help equip himself for understanding children's behavior the parent or teacher should (1) dig back into his past in an attempt to reactivate his own childhood feelings; (2) observe children carefully; (3) take advantage of the research that has been done in child behavior; and (4) use whatever native "tact" and sensitiveness he has (Dr. Hymes calls it "hunch") in understanding children.

In judging any particular form of behavior the parent or teacher should ask himself the following questions: (1) Is it normal for the particular stage the child is in? (2) What need is he trying to express? (3) Am I considering the influence of his present environment? (4) Is the youngster aware of what is expected of him?

An important idea that Dr. Hymes stresses is that growth is a slow process; children should be allowed to grow in their own way and at their own pace; the only way in which the adult can stimulate growth is in acting as guide and providing the proper opportunities.

Permissiveness within limits seems to be the keynote of Dr. Hymes's philosophy. To those who point an accusing finger at the parent or teacher who possesses a permissive attitude, he would have this to say:

"Our easy-goingness is not something we have slipped into. It is something we have worked for. To develop a tolerance, to develop an acceptance, to build inside of ourselves a real capacity to enjoy children and what they have to do—none of this comes without effort. But the effort is worth while if the goal of human relations is to build a world of free people able to work with others because they are able to live with themselves."

An important book.

IDA KLEIN STERNBERG.

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ADVANCES IN UNDERSTANDING THE OFFENDER. Edited by Marjorie Bell. New York: National Probation and Parole Association, 1950. 312 p.

This 1950 Yearbook of the National Probation and Parole Association contains papers read at the Forty-Third Annual Conference of the association in Atlantic City in April, 1950, and at the Congress of Correction in St. Louis in October, 1950.

The first contribution is by J. Howard McGrath, at that time United States Attorney General, who, in his article, *Federal Responsibility for the Youthful Offender*, particularly refers to the work of the Federal Bureau of Prisons in the field of local jail inspection and the

administration of federal detention facilities. Commenting upon the National Training School for Boys in Washington and the newly constructed correctional institution for federal offenders at Englewood, Colorado, the attorney general states that "the federal officials have strengthened the training and treatment program, have emphasized counseling, and have inaugurated sponsorship and group-psychotherapy programs which are proving extremely successful."

In 1923, the first draft of a Standard Juvenile Court Act was formulated by a committee consisting of representatives of the United States Children's Bureau and the National Probation Association, and it served as a sample to many state legislatures. During the following years it was revised several times in order to make full use of the more recent developments in the field of detention, court procedure, social investigation, and case-work. The most recent draft was published in 1949 and its various aspects are presented in this book by Justine Wise Polier, Justice of the Domestic Relations Court, New York City, in her paper, *The Standard Juvenile Court Act, 1949*. It should be pointed out that for the first time this present draft includes optional provisions that would extend juvenile-court jurisdiction and procedure to matters of family welfare, especially in the field of support of dependents.

Along the same lines Judge Elwood F. Melson, of the Family Court of Wilmington, Delaware, contributes an article, *Conserving Family Life Through a Specialized Court*, in which he describes the basic principles of family-court jurisdiction and procedure.

A very challenging idea that has been put into practice with considerable success in several communities is the subject of the article, *The Rôle of a Citizens Advisory Council in a Juvenile Court Program*, by Charles H. Boswell, Chief Probation Officer, Juvenile Court, Indianapolis, Indiana.

A group of five articles deals with "Institutional Treatment of the Delinquent." S. R. Slavson, Director of Group Therapy, Jewish Board of Guardians, New York, contributes a paper, *Social Reeducation in an Institutional Setting*, in which he describes, *inter alia*, an experiment at Hawthorne-Cedar Knolls School with a group of girls for whom analytic group psychotherapy or interview group psychotherapy was found suitable. He also speaks of experiences with self-government in an institutional setting, but emphasizes that "participation must be genuine" and that pseudo-democracy can have a very detrimental effect.

Two other articles in this series are *The Correctional Institution from the Viewpoint of the Social Agency*, by Dorothy L. Book, Dean, Boston College School of Social Work; and *Relationship of the Correctional Institution to Community Agencies*, by Charles W. Leonard,

Superintendent, Illinois State Training School for Boys, St. Charles. Both papers stress the need for clarity in the relationships between the institution and case-work agencies, family-counseling agencies, schools, courts, and other community resources.

Elizabeth A. Betz has made a special study of methods of release from training schools on a nation-wide scale. Her paper on this subject is an excerpt from her master's thesis at New York University. This is the first time in many years that such a comprehensive survey, based on questionnaires returned from 88 public training schools for juvenile delinquents, has been undertaken. All the states but two, as well as the District of Columbia and the Federal Government, are represented in this study, which deals with such problems as parole preparation, determination of eligibility for release, rules governing parole, placement on parole, supervision on parole, and termination of parole. ("Parole" is used here only because it is still the generally accepted term so far as the institutions are concerned; as a more apt term, the word "after-care" has been suggested.)

The following specialists have contributed articles on various aspects of "Organization of Probation and Parole Services": Randolph E. Wise, Parole Consultant, National Probation and Parole Association, on "Parole Progress"; George K. Killinger, Chairman, United States Board of Parole, on "The Functions and Responsibilities of Parole Boards"; Richard T. Smith, State Director of Probation, New Hampshire, on "Statewide Organization of Probation Services"; Russell G. Oswald, State Supervisor, Wisconsin Bureau of Probation and Parole, on "Professionalizing Services"; and Gordon S. Jaeck, Chairman, Minnesota State Board of Parole, and Director, Probation and Parole, on "Separate or Combined Probation and Parole Caseload—Must There be a Conflict?"

A significant gap in existing services is pointed out in two articles: *Probation and the Homeless*, by Elmer W. Reeves, Administrative Assistant to the Chief Probation Officer, Court of General Sessions, New York City; and *After the Training School—What?* by Richard Clendenen, Consultant on Training Schools, United States Children's Bureau. Both authors are concerned with adolescents, either on probation or on parole, who should not return to their own families because of the inadequacies of the home environment, which, in many instances, was one of the main contributing factors to their delinquency. Both writers recommend the setting up of group homes or residence clubs (pp. 71 and 176-77).

Dr. Melitta Schmideberg presents several case histories in her article, *The Criminal Psychopath*. She states that "the psychopath's inability to endure friendly emotions is a serious treatment problem. His depersonalization must be broken through, and he must be taught

to tolerate the emotions stirred up by good treatment." In a companion article, *The Sex Offender*, Dr. Leo L. Orenstein cites several cases. He warns that "our actual experience of treatment results for this group is so limited and circumscribed as to make it difficult to draw valid conclusions." In view of the fact that even a well-trained psychiatrist can treat only a relatively small number of individuals, he suggests that we "accept our present-day experiments in this field as a good beginning rather than as an adequate solution to the problem of the sex offender." Louis D. Cohen, of Duke University, in his article, *Psychological Techniques in Probation and Parole Work*, describes the application of several modern tests, such as the Rorschach, the thematic apperception test, Dr. Saul Rosenzweig's test, and Dr. Karen Machover's test.

The final series of articles deals with "Probation and Parole Abroad." Specifically, St. Alban Kite, of the Department of Institutions and Agencies in New Jersey, reports on his experiences in Germany, where he acted as an adviser of the American Military Government to the German authorities in their newly developed parole programs. Edmond FitzGerald, Chief Probation Officer, Brooklyn, New York, gives a thrilling account of his experiences as an expert consultant on probation and parole to the newly formed state of Israel.

Appended to the book is a legal digest, prepared by Sol Rubin, of the National Probation and Parole Association, which covers new legislation and court decisions in the field of juvenile and domestic-relations courts, probation and sentencing, parole and correction.

This book, like many of its predecessors, is a most valuable tool of information on current thoughts and experiments in the vital field of dealing with the offender, juvenile as well as adult.

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CONTEMPORARY CORRECTION. Edited by Paul W. Tappan. New York: McGraw-Hill Book Company, 1951. 434 p.

In the preface to this volume, one of the McGraw-Hill Series in Sociology and Anthropology, the editor, Paul W. Tappan, states that the subject matter covers general administration and policy, the varied types of correctional institution, the highly specialized methods employed in them, and the field of treatment outside the institution. Thirty-one outstanding authorities in each of the various fields of correctional practice contribute to this panoramic view of contemporary correction.

The book is divided into five parts: (1) *Correction: Preliminary Considerations*; (2) *Administrative Organization and Classification*;

(3) *Programs in the Correctional Institution*; (4) *Types of Correctional Institutions*; and (5) *Extramural Treatment*. Individual chapters that will be of interest primarily to workers in the field of mental hygiene are those on psychiatric, psychological, and case-work services, by R. A. Brancale and K. L. M. Pray; on group therapy, by L. McCorkle; on probation—case-work and current status, by R. A. Chappell and W. C. Turnbladh; and on crime prevention, a confusion in goal, by E. J. Lukas.

It is of some consequence that the scientific approach to the criminal from the standpoint of correction differs so markedly from the standpoint of prevention. It raises a serious question in that there is no general agreement on the fundamental concepts of a basic psychology universal for all disciplines that deal with human beings. The dynamic psychiatrist would not concur with Tappan's orientation when he states in the first chapter, *Objectives and Methods in Correction*, that "criminals are not generally neurotic, psychotic, or psychopathic."

For the clinician working in the field of criminology, it is instructive to obtain a perspective of what goes on after the criminal is imprisoned. To become aware of the problems involved and the varied resources available can enhance the knowledge of the clinician. Individuals responsible for the correctional phases of dealing with the criminal can also benefit by knowing more of the clinical point of view.

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DEMENTIA PRAECOX, OR THE GROUP OF SCHIZOPHRENIAS. By Eugen Bleuler. Translated by Joseph Zinkin, M.D. New York: International Universities Press, 1951. 489 p.

Bleuler's monograph on schizophrenia is the corner stone upon which all modern psychiatry rests. Its publication in English is certainly the most important event in this field for the past decade.

For any one, layman or professional, this volume will provide both a more comprehensive and a more comprehensible picture of schizophrenia than any other publication. It is unlike many other "classics," in that its language is not esoteric nor are its concepts abstruse. In other words, it is a book that can be recommended without qualification to any one who wishes to know exactly what is meant by the term schizophrenia.

The curious history that delayed its translation into English for more than forty years is not pertinent to this review. The event, however, is not unlike the translation of the Bible into the Vulgate after centuries of inaccessibility.

The monumental character of this particular volume is apt to be forgotten in the light of at least a quarter of a century's acceptance of its contents. Although Bleuler has acknowledged his great debt to Kraepelin, it is almost certain that without Bleuler's own "codification" and the provision of an etiological generalization relating the *schizophrenias*, Kraepelin's classification would have suffered the fate of those of Wernicke, Meynert, and others. This is probably best indicated by the fact that, after the publication of this volume, Kraepelin attempted to revise his classification, but any changes he proposed subsequent to this monograph of Bleuler's were disregarded.

Although considerable dissatisfaction exists among psychiatrists as to the validity and reliability of Bleuler's classifications, they nevertheless remain far more acceptable than any proposed alternative system. The only serious alternative proposed was the classification of the Meyerian psychobiologists. Partly because of the unwieldiness of Meyers' terminology and partly because the classifications were still essentially the same (with the psychobiologists stressing the entity as a reaction rather than a content), the use of this nosology has been retained virtually intact. In Bleuler's own opinion, which he states quite forthrightly in this volume, the sub-classifications of schizophrenia are extremely tentative and are proffered only until more adequate discrimination of the various *schizophrenias* can be achieved. That this has not been accomplished is evidenced by the fact that the official nomenclature of the American Psychiatric Association is pristine Bleuler.

The concept of the *schizophrenias* as resulting from "loss of associative affinities" has not fared so well, but no systematic and satisfactory substitute has been offered. The psychoanalysts have proposed an alternate genesis of the disease, but have done so almost entirely within the framework of Bleuler's classification. Another large school of workers have also accepted the classification, but have sought for explicit biochemical or physiological causation.

Despite fairly widespread criticism both of the classification and of the theory, no competing systems have yet been offered that seem likely to cause any revolutions in this field in the immediate future. Any one reading the volume can, therefore, be assured that for at least the next decade this volume will provide the last word on what is encompassed by the designation given to this largest group of hospitalized individuals.

The specific defects both of the classification and of the theory are not difficult to enumerate. The criteria for class membership are poorly defined and even contradictory. The theory offered could serve equally well to "justify" almost any conceivable classification and, therefore, bears little relationship to the categories themselves. The

whole concept of the disease is so structured that crucial experiments to demonstrate the validity either of the theory or of the classification cannot be performed. It is highly probable that the failure to find physiological and biochemical relationships with this group of mental diseases is due to this inadequate conceptualization, and that understanding will not be achieved until a more adequate system is demonstrated.

Despite these criticisms, this volume still remains the real basis for present-day diagnostic psychiatry and will continue to be so for some time to come.

The translation itself, by Dr. Joseph Zinkin, of the United States Public Health Service, is both accurate and readable, despite occasional "Germanizations" of the English. The publishers are to be complimented on having undertaken a major responsibility which, probably to their surprise, will end up on the "best-seller" psychiatric list. Any one working in the field of mental health, or even peripherally interested in it, is both shirking a responsibility and denying himself a real pleasure if he does not read this volume.

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GENERAL THEORY OF NEUROSES. By Rudolph Brun, M.D. (Twenty-two Lectures on the Biology, Psychology, and Psychohygiene of Psychosomatic Disorders.) New York: International Universities Press, 1951. 468 p.

This book constitutes Parts 3 and 4 of a comprehensive series on the general subject of mental hygiene, edited by H. Meng. This series, consisting of seven volumes, is entitled *Mental Hygiene, Science and Practice*, and it is essential to keep this in mind in order to appreciate fully the broadly conceived and highly ambitious approach taken by the author and the important place that was given his work in the series. The other five volumes deal with the following subjects: (1) a general introduction to mental hygiene; (2) a translation of Beers's *A Mind That Found Itself*; (3) practice of mental hygiene; (4) analysis of destiny (a study of the family background of personality disturbances); and (5) instinct and civilization.

It is a well-recognized fact that the scientific foundation of the present-day mental-hygiene program is largely derived from the study of the neuroses, and since the series deals both with the theoretical and with the practical aspects of mental hygiene, it is obvious that whoever is assigned the subject of the neuroses would have to attempt an objective, scientific approach to their causes and manifestations. Actually, the author proposes a theory that attempts to develop a

systematic basis for the psychogenesis of the neuroses and, at the same time, to demonstrate objective evidence of the *biological* and *physiological* aspects of the manner in which the psychogenetic factors affect the personality and lead to the symptoms that are manifested in the neuroses.

Brun starts out with a definition of the neuroses within the framework of personality disturbances in general, regarding all of them as "primary disorders of the instinctive life or hormopathies." Within this large group, he recognizes two general subdivisions, the organic and the functional. Under the *organic*, he places the following: (1) dysglandular hormopathies which are the results of disease of the endocrine glands; (2) constitutional-endogenous disorders, among which he places the schizophrenias, the manic-depressive psychoses, and the psychopathies; and (3) the cerebral hormopathies due to organic disturbances of the brain. The second large group is that of the *functional* hormopathies or the neuroses, and here, in keeping with the original Freudian classification, he recognized two types: (1) the functional-organic (toxic) or the so-called actual neuroses, including neurasthenia, anxiety neurosis, and fright neurosis; and (2) the psychoneurosis proper, in which he places hysteria, phobia, (anxiety hysteria), and the obsessional neuroses. Also included in the last group are the so-called character neuroses and the mixed neuroses.

The present volume deals entirely with the second large group—namely, the functional instinctive disturbances or the *neuroses*. In his historical survey, Brun undertakes a systematic analysis of the various theories that have been advanced to explain the causation of the neuroses, refuting some, accepting others, either wholly or in part, but coming to the general conclusion that the most adequate theory at the present time is the one advanced by the psychoanalytic school.

He then proceeds with a systematic presentation of this theory and an attempted demonstration of a physiological basis, in regard both to the manner in which the neuroses develop and to the manifestations that they present. This physiologic substratum expresses itself in three types of phenomenon: neurobiochemical, neuropathological, and reflexological. A neurobiochemical component can be postulated as consisting of disturbances in the endocrines, in the vegetative nervous system, and in the equilibrium of the blood-brain barrier.

In a general discussion of the work done in both of these fields, he develops the point that in the neuroses, we have manifestations of disturbances in the whole vegetative nervous system and also in the exchange of substances between the blood and the nervous system. This may serve as a constitutional background that provides suitable soil for the development of neuroses, as well as representing effects produced by the faulty development of the instinctual organization.

A similar theory is developed in relation to the conditioned-reflex functions, in which the author sees a physiological counterpart of some of the psychogenetic mechanisms that are found in the neuroses. Finally, in some of them, particularly the hysterias, he advances the theory of actual functional disturbances in the extra-pyramidal system, which then furnish the substratum for a good many of the sensory-motor manifestations in hysteria.

To complete the discussion of these organic aspects of the neuroses, he discusses the hereditary or constitutional factors that are involved, accepting the proposition that in most, if not all, of the neuroses, there is a constitutional weakness in the instinctive structure of the personality which is inherited and which expresses itself primarily in disturbances of the above mentioned organic functions.

The author then proceeds to discuss the basic biological and psychological aspects of the instincts. The former are developed on the basis of investigations of the instinctive patterns of behavior of insects and some of the higher species. The latter is practically entirely a discussion of the Freudian theory of the development and manifestations of the instinctive basis of human behavior. He then proceeds to the more detailed discussion of the various syndromes, starting out with what he terms the functional, organic (toxic) types—namely, the anxiety neuroses, neurasthenia, and the fright neuroses. Particular attention is paid to the anxiety neuroses, which—again in keeping with the original Freudian idea—he considers as primarily an expression of the damming up of instinctual (libidinal) forces and the consequent toxic effects on the individual.

Although the reasons for the occurrence of such interference with a normal discharge of libidinal energy may admittedly be largely psychogenetic, nevertheless, its effects, in terms of symptoms—i.e., anxiety—are organic or toxic in origin. The suggestion is also made that once such a neurosis has been established, psychiatric superimposition in terms of somatic complaints, phobias, and other disorders may develop as secondary symptoms.

The situation is different in the second group of the neuroses, the so-called true *psychoneuroses*. Here the etiology is entirely psychological, although a constitutional biological weakness has to be presumed in most cases and also the actual manifestation or release of symptoms has organic counterparts. Here Brun deals with the hysterias, the phobias, and the obsessive neuroses. The distinctive features of the conversion hysterias are presented as follows: "The instinctual affect as such—i.e., the affective representative of the instinct—is repressed; its objective representative, on the other hand, is often still capable of becoming conscious. Yet, on account of the withdrawal of the libido, it has become affectless . . . the result is the

conversion of the affect into a physical symptom which represents a displacement substitute for the symbolic gratification of the desired (forbidden) wish impulses." As contrasted with this, "in the phobias the affective representative of the repressed instinctual impulses is retained as affect at least in form . . . the primary instinctual affect has been changed, converted into another and usually a contrary affect; thus pleasure is converted into anxiety. . . . This converted affect has detached itself from its original objective and has attached itself to a similar substitute objective or situation." Finally, "in obsessional neuroses, the instinctual complex is reduced in the form of reactive, compulsive thinking or in the form of a reactive action—the compulsive act—carried into the outer world."

It is not possible in this review to present adequately the sequence of reasoning, the great variety of clinical and investigative data, and the comprehensive nature of this work. If a theory that combines the broad concept of psychoanalysis with objective evidence of the biological basis of it can be developed, this author is certainly most adequately prepared for such a task. He combines a thorough knowledge of the theory and practice of psychoanalysis with an extensive experience in the general field of neurophysiology and general biology. There is a wealth of material both clinical and investigative, most of which is contributed by the author himself. Whether this attempt is entirely successful, however, is another question. As long as the author remains in either one of the two fields—that is to say, biological investigation or psychotherapeutic practice—one follows him without any difficulty and without finding any inconsistencies. The attempt to combine the two, however, frequently leaves one rather sceptical, to say the least.

It is true that his main purpose is to develop a theory that could serve as a basis for further investigation. But even theoretical concepts must be kept alive by some basic evidence of fact and here is where we find very frequent gaps which tax the imagination of the most willing reader. What evidence do we have, for instance, that the blood-brain barrier is actually disturbed in any of these conditions? What evidence, furthermore, is there that demonstrable disturbances in the endocrine function can be found in the neuroses? Where, furthermore, can we find a basis for the assumption that extra-pyramidal disturbance in function occurs in cases of hysteria? It is true that in disturbances of endocrine function we do frequently see psychological manifestations. It is also true that some similarity may exist between the clinical manifestations of the extra-pyramidal pathological conditions and some neurotic somatic symptoms. To support the author's thesis, however, we would have to demonstrate evidence of histological or chemical pathology in the neuroses. One can be in sympathy with the author's point of view and fervently hope that some

time in the future such evidence will be demonstrated, but at present it is not possible to agree that such a basic interrelationship exists.

Whether or not one agrees with the basic conclusions, however, this contribution is highly worth while. It is provocative and stimulating. The clinician will find in it a rich variety of material and many helpful suggestions in the evaluation and treatment of the neuroses. To the investigator it offers many leads for further study and the possibility of testing the validity of a very important and promising field in the study of human behavior.

WILLIAM MALAMUD

Boston, Massachusetts

A PRIMER FOR PSYCHOTHERAPISTS. By Kenneth Mark Colby, M.D.
New York: The Ronald Press, 1951. 167 p.

This little book, as the name implies, is intended "to present in simple and readable form the elementary principles of psychotherapy for beginners in this professional specialty." The contents are suggested by the chapter headings—*The Patient, The Therapist, Time and Space Conditions for the Interview, Behavior During the Interview, Beginning the Therapy, The Middle Course of Therapy, and Ending the Therapy*. There is also a chapter on the psychotherapy of the schizophrenias.

Most of the questions likely to be asked about analytically oriented psychotherapy, its aims and methods, are answered briefly here, accompanied by numerous illustrative excerpts of dialogue between patient and therapist. This latter enlivens and clarifies many of the points. The author states specifically that his theory of neurosis and concept of cure are psychoanalytic (p. 8), so a comprehensive presentation of any other forms of psychotherapy, individual or group, is not found, nor is it to be expected.

One may suggest that there are better reasons for using a couch for the patient than a desire of the therapist not to be stared at (p. 32). Such a reason is not fair to the patient, and not exactly flattering to the therapist! More vigorous exception may be taken to the statement (p. 38), "By the time one has become something of a psychotherapist, his medical diagnostic judgment has suffered a disuse atrophy of such proportion that he is really no longer a reliable medical man." If this statement be true, our "psychosomatic psychiatry" brethren should cease fire. If a physician becomes so specialized that he cannot take blood pressure, or listen for râles or heart murmurs, he would do well to suspend practice for a while and return to medical school. If psychotherapy is an integral part of medicine—as it is generally claimed to be—and if the therapist is a physician, there would seem

to be hardly a better way to cement the patient-doctor relationship than by demonstrating practically an interest in the patient's soma as well as his psyche.

These are, however, perhaps but trivia, for the book is well presented and instructive, and adequately serves the purpose for which it is intended.

WINFRED OVERHOLSER

*Saint Elizabeths Hospital,
Washington, D. C.*

A FEW BUTTONS MISSING. By James T. Fisher, M.D., and Lowell S. Hawley. Philadelphia: J. B. Lippincott Company, 1951. 282 p.

This is a charming book. It is an autobiography with a live and very lively ghost. The ghost (Hawley) says: "I am, I believe, one of the few laymen who has sat quietly taking notes and asking questions, while the psychiatrist lay on the couch giving voice to his thoughts at random. The story is Dr. Fisher's story. It is the story of his life and his experiences."

The book possesses those three qualities without which no psychiatric text for laymen should ever reach a press. It can harm no one. It will inform and instruct many. It will entertain all readers.

Dr. Fisher is presented as a middle-of-the-road psychiatrist who has sampled many techniques with surprisingly little indigestion. He talks about himself, his experiences, and his patients and, as he does so, he constructs a picture of the major psychiatric hazards. The picture is instructive.

One of the authors is a brilliant and acute phrase-maker, as witness the following: "The charge has been made that psychiatry . . . is composed of a strange hodgepodge of psychology, pathology, philosophy, anthropology, and man's insatiable desire to hear himself talk." I enjoyed this book.

GEORGE H. PRESTON

*Ft. Myers Beach,
Florida.*

MORE POWER TO YOUR MIND. A GUIDE TO MORE EFFECTIVE LIVING. By G. Milton Smith. New York: Harper and Brothers, 1952. 180 p.

This is a helpful and clearly written book for the average person. Geniuses and neurotics may find suggestions that they can apply to their special problems, but everyday people in everyday situations are particularly in the author's mind. Mr. Smith's vocabulary is free from special terminology; he does not belong to any special school, so

far as one can gather from his understandable and sometimes homely phrases; his illustrations are picturesque and to the point.

John Chamberlain, in his preface to the book, says: "The important thing for the individual is the achievement of . . . a personal philosophy, a set of values, that will tell him when to make compromises and when not to make compromises" in relation to adjustment, that key word of most popular psychologies. Common sense is always a help and it receives less attention from these popular writers than it should. Dr. E. L. Thorndike once said that psychology begins where common sense leaves off. That implies that common sense must at some time have been present. Milton Smith emphasizes Thorndike's words by saying of his book, "It offers some organized common sense on mental health and power, which can act as a guide to more effective living" (p. 4).

One important characteristic of the book is the relatively equal importance the author gives to *mind*, *body*, *spirit*. Often we are led to believe that difficulties invariably start in one of these divisions of the human make-up and can always be overcome by dealing with that particular division. *Mind* just now is the favorite; it used to be *body*. Effective living, according to our author, can be best achieved if "we combine with the wisdom of the mind the wisdom of the body and the spirit" (p. 3). Hindrances to effective living usually come from failing to satisfy human needs in one of these divisions, but needs in one division are either furthered in their satisfaction or hampered by conditions in either or both of the other, as psychosomatic medicine is beginning to show us so vividly. Too often students in this field fail to point out the contribution that the spiritual can make. And another application of this principle which is often omitted is phrased as follows: ". . . if poorly managed emotions and wrong mental attitudes can have a harmful influence, well-managed emotions and sound mental attitudes can have a beneficial influence" (p. 133).

Perhaps the most common emotional ills of the average man are discussed constructively in the chapter on "Conflict, Anxiety, and Indecision." The author urges action, with insight if possible, but he says, "The advantages of action in general far outweigh the risks" (p. 88). This sounds too simple to be a real solution, but overcoming the inertia of indecision, or the fear that often accompanies or causes conflict and always anxiety, is not a simple matter. Here, again, action is urged. Suspense is devastating; in action there is little time for fear. "There is a spread of decision to the important area of conflict rather than the former spread of indecision. The new mood tends to carry over. We gain confidence from our record of decisiveness: we know it can be done, that we can do it" (p. 83).

It must constantly be kept in mind that this book is not dealing

with the neurotic personality, but with the *normal* personality—if there is such a thing. For the average man there is what the author calls a trial-and-error procedure. We must not be held back from this by fear of making mistakes. "Science progresses in this way, and the method of science can be applied to everyday life" (p. 88). Also quiet, calm deliberation is a method well worth trying as a prelude to action and this may be regarded as the contribution of spirit.

The matter of action is also emphasized in the stimulating chapter on "Sex and the Needs of the Self," especially in the section on the family. The author points out again the fact that there are no universal answers to questions about relations between parents and children, or between husband and wife, even to the possible question of infidelity. Frankness in dealing with children's questions about sex, and harmony in marital relations are important matters. One must not expect perfection in family relations; and where mistakes are made or serious failures occur, the quickest way, we are told, "to expiate our sins is to get started on a new and useful course of action, not to go about in sackcloth and ashes" (p. 145).

In his final chapter, the author draws together the various emphases in his book by pointing out the importance of *Spirit*. He does not define or set down principles of action. The spiritual is concerned with the "finer emotions and sentiments." Through what is said here the author makes his own peculiar contribution to a guide to more effective living, a contribution that, as we have said, is too often omitted from books of this sort.

Here, as well as in the earlier chapters, he takes into consideration individual differences among distressed people and lays down no rules, but through well-chosen quotations and wise similes suggests higher sources of power.

This chapter is a fitting and somewhat unusual ending to a psychological discussion of human needs and their healthful satisfaction, and it adds an atmosphere of strength and confidence to suggested solutions for ordinary human problems.

ELEANOR HOPE JOHNSON.

Hartford, Connecticut.

THE HOMOSEXUAL IN AMERICA: A SUBJECTIVE APPROACH. By Donald Webster Cory. New York: Greenberg, 1951. 266 p.

It was no surprise to learn that, in a very short time, *The Homosexual in America* has become, in considerable sort, a homosexual *vade mecum*. The book is well-written and reasonably objective, and should assume an authoritative position in the underworld, or half-world, of the sexually maladjusted. One homosexual of considerable

intellectual gifts remarked that there was nothing in the book that he did not already know, but that he was thankful to find it all in one place and so well put.

The book is called "a subjective approach," but one finds little therein to give us any clues to the personality, much less the history, of the author. It is a treatise. It attempts an exposition of the place of the homosexual in American society, and it may be regarded as, in many senses, a homosexual apologetic. Unfortunately there is very little new in the sociological approach the author takes.

Sociologically, according to the author, the homosexual is to be regarded as a member of a minority group, and, therefore, subject to all of the liabilities, disabilities, and privations that membership in a minority group implies. Furthermore, the author points out that the homosexual is a member of a particularly inarticulate minority group. No one dares come out publicly and state that he is a homosexual and undertake to speak for those similarly situated. The homosexual is compelled to suffer in silence and submit to whatever an unkind fate offers, lest further evil be visited upon him. So, when one observes unlovely characteristics among homosexuals, it is well to use the same criteria of judgment one hopes to apply to the undesirable characteristics of other minority groups.

The descriptive material as to the folkways of homosexuals seems accurate enough. One is tempted to take issue with the author's use of the epithet "gay" in describing the homosexual. The gaiety to be observed in a homosexual bar is certainly at best a synthetic gaiety. As a matter of fact, precisely the opposite quality is apparent to the observer who is willing to look for a moment below the surface. Homosexuals are much more apt to be sorrowful rather than gay people. Twenty years of work with and for homosexuals leaves little suggestion of their blithesomeness. If the homosexual world wants to apply some special term to itself, "gay" is more than a little inaccurate. The word *homosexual* itself, although not completely descriptive, lives on as a term that can be understood. "Sex variant" seems more accurate, but it may be too academic for general use.

There is a certain pessimism in the author's acceptance of homosexuality as a final state. So far as he can see, it is impossible for the homosexual to change his way of life, and he feels that sublimation will lead only to dangerous repression. On the other hand, there is a healthy realism in his counsel that "what can't be cured must be endured." The homosexual must live with himself twenty-four hours a day; therefore, he is well-advised to learn as much as he can about himself. Unfortunately, the author says little or nothing about the unseen handicaps inherent in the homosexual way of life. He dismisses the police and the blackmailer as occupational risks, and says

quite properly that the public authorities will aid men who fall prey to the extortionist. He is singularly silent about the loneliness that all homosexuals must face, and says nothing about their frantic search for companionship. He blinks their sorry substitution of sexual activity for the affection they seek. He says nothing about their lack of family, home, or roots, and there is a complete absence of any mention of the tragic old age of homosexual men.

The Homosexual in America serves a useful rôle in bringing to badly informed homosexuals something a little more authoritative than the uninformed gossip and absolute trash that passes as current literature. The author gives in his bibliographies extensive reference to the homosexual in fiction. The book will serve to combat the intolerance of those who consider homosexuals pariahs and outcasts.

Despite what the author says, however, it is not a book lightly to be given to the parents of homosexuals. There is too much optimism on the author's part that the homosexual can work out a satisfactory adjustment for himself. The well-adjusted homosexual, as I have so often said, is rare. And living, as the homosexual does, under conditions ranging from downright persecution to amused tolerance, it is almost impossible for society to expect him to make a good adjustment. Until some of the antiquated laws on the statute books relating to the homosexual are dropped, the chances of a universal good adjustment for him are poor. But it is possible that understanding of what the homosexual has to face within our present social mores may make the community more conscious of his problem and less inclined to ostracize those who cannot conform to the sexual demands of the majority.

GEORGE W. HENRY

*The George W. Henry Foundation,
New York City*

SEX AND THE LAW. By Morris Plosecwe. New York: Prentice-Hall, 1951. 285 p.

In no other department of life does the Anglo-Saxon blink the unpleasant as thoroughly as he does in that of sex. Here the example of the ostrich, of sticking its head in the sand until the menace has subsided, is almost universally followed. When sex must be dealt with by the law, Judge Plosecwe describes the courtroom atmosphere in this wise:

"When an attendant in the New York City Magistrates' Courts formally opens the hearing on a charge of overt homosexual behavior with the reading of the complaint in open court, his normally stentorian voice drops to a whisper. He shares a widespread feeling that acts of sexual

perversion are not matters for public consumption. Even where sexually deviant behavior comes to the attention of official agencies, it must be handled quietly and as discreetly as possible. It may be the subject of gossip; the derision of the 'pansy,' 'fairy,' or 'queer' is frequent in private conversation. But public presentation of the problem of perversion, even of its significance to the community, is generally taboo."

There are still those who think it possible to make men good by passing an act of Parliament. Blackstone defined the law as something ordained by the king, "commanding what is right, and prohibiting what is wrong."

In the old Criminal Court Building in New York, there was a picture of Justice in one of the courtrooms. It was a conventional affair. The lady was quite decently habited and passably good-looking. In one hand she held the sword of justice and in the other a pair of scales—and she was effectively blindfolded. There are many lawyers to whom this picture represents the highest ideal of justice, dwelling on its own particular Olympus, quite apart from the actualities of life. Sin, negligence, and ignorance were carefully charted in the books, and sinners coming before the courts were somehow to be fitted into the Procrustean bed. So long as the letter of the law was followed, all was reasonably well. If a man was found guilty after a trial in which all the formalities were conscientiously observed, then the punishment was written in the book to fit the crime. And that was that.

There has arisen in the land a new concept of criminal justice that sometimes goes under the name of "sociological jurisprudence." Holmes and Brandeis, Cardozo and Roscoe Pound, and, in another sphere, Morris Raphael Cohen, have laid the foundations of the new ways of bringing the law into realistic dealing with errant human nature and conduct. Morris Plosecwe, now a judge of the City Magistrates' Court, has long shown his ability to follow the footprints of these giants.

Sex and the Law examines the present state of the law with respect to marriage and divorce, annulment, and legitimacy. It then passes on to the offenses against the criminal law: fornication, adultery, and indecent exposure. From there it considers the serious offenses of rape, homosexuality, and the crime against nature, so-called. It looks at the psychopathic sex-offender laws and crimes against children. It discusses prostitution, marriage, sex crime, and social policy. And it has, of course, an excellent bibliography.

If we take the law literally, only one sort of behavior with respect to sex is permitted human beings. That is sex within the marriage relation, preferably with a view to procreation. The law is very much in agreement with what is so plainly set forth in the marriage service of the English Prayer Book. Every other mode of sexual expression is *mala prohibita* in varying degrees. To which assumption, Dickens

well says: "If the law supposes that, the law is a ass, a idiot." No matter how much one may be disposed to quarrel with the figures Professor Kinsey has turned up, it seems established beyond too much doubt or wishful thinking that sexual irregularity is a commonplace. This is a fact. Now, what can be done about it?

As Dean Pound so clearly points out in his introduction to the book, we are in a hopeless muddle so far as statute law is concerned. There are 48 states in the Union with 48 criminal codes. The statutory regulations in regard to contracting a marriage are so diversified that a couple finding the laws governing the issuance of marriage licenses too stringent need not go very far to find a nearby state that is more accommodating. And if the divorce laws in one's own state are too rigid, there is always a state that will hand down an easy-to-obtain decree.

So far as sex offenses are concerned, each state has its own notions of what constitutes a crime and how the crime shall be punished. There is a very wide difference in the penalties imposed by different states for the same offense. Our legislators have relied hitherto, and still rely in great measure, on prison as the cure-all. In recent times, however, the lawmakers have discovered a new panacea for sex offenses — psychiatry. Whereas formerly offenders were shipped off to jail to repent and possibly reform, men are now being sent to hospitals for the criminal insane, to be cured.

Unfortunately that particular solution has proved too easy. Sooner or later the hospitals release their patients and the courts have discovered that there is very little difference between imprisoning a man in a jail or in a hospital. Many states enacted laws forcibly hospitalizing all manner of sex offenders, convicted or otherwise, only quietly to forget them. Here we have the real dilemma. The community must be protected from sex offenders, especially those who molest children. Sex offenders are people about as badly in need of help as any one. Can they be helped and the community protected at the same time?

Judge Ploscove's experiences in the criminal courts and as a socio-legal philosopher entitle his views to be heard with more than a little respect. His book is no mere compendium of state laws, with neat tables of penalties to be exacted for each offense. Here we have a real consideration of how the laws concerning sexual irregularity came into being. The old common law concerned itself little with this area of conduct; most of it came under the English ecclesiastical courts. Therefore, the twentieth-century student, in order to obtain a proper historical perspective, must familiarize himself with the manner in which our criminal codes, as they deal with sex offenses, grew out of the common law and the canon law.

It may come as a considerable surprise to learn that the English ecclesiastical law still had jurisdiction over sex offenses in considerable degree until the middle of the nineteenth century, although the powers of these courts had been seriously curtailed long before that time. This is all the more interesting as we contemplate the deference paid by judges and legislators to the views of the churches in every aspect of sexual activity.

The conclusions of the book are sound and well-reasoned. In an ideal society, Judge Ploscove suggests, one would do well to follow St. Paul's advice, and let each man be the husband of one wife or remain continent. Things would be much simpler thus. Unfortunately human nature is still imperfect, and the Old Adam persists. Therefore, we would be well advised to make marriage more difficult to contract lightly, and surround its entrance with proper safeguards.

By the same token, there must be considerable rethinking about our divorce and annulment laws. It is time for the divorce courts seriously to consider making use of expert advice. It is pointed out that the New York domestic-relations courts, which have only limited jurisdiction, have a staff of probation officers, social workers, psychiatrists, psychologists, and so on, but this type of service is nonexistent so far as the courts with power to grant divorces are concerned.

Society should insist that a matrimonial case must be tried far differently from a tort or a criminal case. We must be more realistic in our notions about the legitimacy of children. And the criminal law stands in need of a complete overhauling in the field of sex offenses. Where crimes are committed that employ force and violence, the penalty must be severe and a deterrent. It must punish those who offend against children. It must curb sex offenses—heterosexual or homosexual—that outrage public decency and give rise to public scandal. It must stamp out commercialized vice. There is no excuse for prostitution of any sort.

There will remain a relatively small number of sex offenders who, for their own protection as well as that of society, require more or less permanent custody. These may have to be taken out of circulation for the rest of their lives. For such of these as do not present a serious escape risk, there might be provision for their earning their way and becoming, within the limitations thought wise for safeguarding the community, moderately self-supporting.

But long-term detention problems require a different type of treatment from those that are simply public nuisances. For the latter, probation on a first offense, with the added benefit of good psychotherapy and perhaps religious counseling, has inhibited a great deal of their more flagrant activity. We must always be careful to distinguish between nuisance and menace.

Long ago John Erskine wrote a book that he called, *The Moral Obligation to be Intelligent*. If we would be intelligent about sex and the law, then we would do well to read, mark, learn, and inwardly digest Judge Ploscove's book.

ALFRED A. GROSS

The George W. Henry Foundation, New York City

THE ADJUSTMENT OF THE BLIND. By Hector Chevigny and Sydell Braverman. New Haven: Yale University Press, 1950. 320 p.

One of the co-authors of this book, Hector Chevigny, is a radio and screen writer who was suddenly stricken blind in New York in 1943. The poignant experiences that he underwent in one of the largest cities of the world were set down by him in an earlier biographical work, entitled *My Eyes Have a Cold Nose*. That book dealt with factors that the writer felt to be basic in the general misconception that exists of the capacity of the blind to enter into and participate fully in the life of the sighted world.

In this text, considered the most outstanding in its field of any yet published, the co-author, Hector Chevigny, reaches what we might term a milestone in his adjustment to blindness. He has extricated himself from his initial confusion, and is now able to evaluate his experience quietly and objectively and go on with the co-author, Dr. Sydell Braverman, to consider the psychological factors, historical and present-day, with which the blind as a group find themselves faced.

The historical background is presented, showing how slowly our treatment of the blind has progressed in the past centuries, from mendicancy through the period of the asylum, to present-day methods and approaches. The new "depth psychology" is employed to illustrate the basis, frequently so obscure, of the misguided public attitudes toward the blind.

Old beliefs are shown to be fallacious in that a shattering of the personality does not follow, by and large, when sight is lost. New muscular coördination and compensation are possible through the new demands made on the other senses, enabling the individual to proceed with the problems of living in a rather normal manner. Clinical studies set forth in the book demonstrate that the general assumption, that the blind operate to a great extent along the lines of frustration, aggression, and the welling of emotion from within, is not borne out by available clinic records.

Of interest to psychologists, educators, and social workers will be the development of the Freudian theory as it applies to those who

are blind, the unconscious, "blindness as a punishment," identification, and so forth.

The major fallacies of the sensory and perceptual life of the blind are reviewed clearly. Again, clinical data do not bear out the theory of the "darkness and void" concepts that until recently have been commonly accepted. It is interesting to note that certain areas, such as the nature of the congenital blind, are not given solution at this date. This awareness of the authors that they do not know "all" again should please educators, psychologists, and social workers. The employment of psychoanalysis in taking apart conceptions of how the blind feel and how they should be treated is presented in a scientific manner. The "assumptions" concerning the blind, on which the sighted world has operated so long, are explained as projections by the sighted of their own thinking upon the blind.

The book pleads for wiser treatment and better understanding of this physically handicapped group and better diagnostic services. There are striking illustrations of the diagnostic ineptitude of agencies dealing with the blind. Stress is laid upon the common failing of so many ophthalmologists who, in failing to give the truth about the loss of sight to the patient, or by delaying the giving of this information, keep the patient in a state of confusion, with the result that he is apt to feel that the situation is much worse than it is.

The recommendation is made that there should be available throughout the country training centers for the newly blinded such as were developed at Avon during the war and at Seeing Eye.

Segregation of the blind as against integration is discussed. The conflict between agencies, each setting forth its own ideas about planning for the blind, the influence of depressions upon the programs of care frequently inaugurated, and the attitudes of the blind themselves toward their regimentation industrially and otherwise, are covered most realistically. The analysis of the practicality of the integration of this handicapped group into well-established rehabilitation programs is developed, and the clear-cut recommendations stand out.

We know that change comes slowly. If, however, professional workers everywhere will take the time to familiarize themselves with this "book of the century," they will find, this reviewer believes, that it is indispensable on the reference shelves of all schools of social work, colleges, and universities and on each worker's desk. It should be a "must" on the list of required reading for social workers in nearly every field.

LAURA E. CARSON

Boston, Massachusetts

THE COLLECTED PAPERS OF ADOLF MEYER. Edited by Eunice E. Winters. Vol. III: *Medical Teaching*. Baltimore: The Johns Hopkins Press, 1951. 577 p.

This volume contains the thirty-four papers in which Adolf Meyer expounds his undergraduate and postgraduate instruction in psychiatry. The papers also contribute specifically to teaching in psychology and medicine.

Very notable additions are obituary biographical sketches of fifteen eminent American and European scientists and teachers in the fields of psychiatry, neurology, medicine, and psychology.

Two outstanding features characterize Adolf Meyer's teaching and both are comprehensively presented in this volume: his basic concept of what constitutes the Science of Man and his methodology of handling teaching material. Dr. Meyer unambiguously discards the Cartesian dualism—division of the human organism into "mind" and "body"—and uses his own concept, embraced in the term "psychobiology" or "objective psychology."

Dr. Meyer introduced the term "psychobiology" into the medical and psychiatric literature in 1915. Its full meaning and scope were best outlined, it seems to me, in a statement he made to a class of students—namely, "psychobiology studies not only the person as a whole, as a unit, but also the whole of the man." Thus, psychobiology regards as its domain studies of normal and abnormal anatomy and physiology of the organs; normal and abnormal functioning of the person; mutual interrelationships between the function of organs and the function of the person; interpersonal relationships; and interrelationships between the function of the person and his environment.

Dr. Meyer was not regarded as a brilliant teacher or as an effective exponent of his concepts and of his encyclopedic knowledge. Yet his methods of teaching seem to me to have been essentially sound. Recognizing that the present-day feelings and behavior of an individual are determined by his constitutional endowment and past life experiences, beginning with early childhood and continuing throughout his life, Meyer, true to the psychobiological approach, considered it essential to study comprehensively the life history of the normally or abnormally functioning individual. To train students in the technique of carrying out such comprehensive personality studies, each student was requested to carry out a personality study of himself under Dr. Meyer's guidance. As described in the paper, *Outline of First-year Course*, emphasis is placed on the formulation of "concrete objective and not merely introspective performances."

The introduction, by Franklin G. Ebaugh, is a significant contribution in that it effectively presents the very fundamentals of Dr. Meyer's concepts and teaching.

The book will certainly be appreciated by students and teachers in medicine, psychiatry, psychology, and the social sciences, as well as by the practicing physician, the psychiatrist, and the clinical psychologist.

S. KATZENELBOGEN

*St. Elizabeths Hospital,
Washington, D. C.*

CLIENT-CENTERED THERAPY. By Carl Rogers. New York: Houghton Mifflin Company, 1951. 560 p.

This is a book that many persons interested in counseling and therapy have been awaiting for some time. We had heard that developments and research had caused Dr. Rogers to feel that his earlier book, *Counseling and Psychotherapy*, no longer adequately presented the "client-centered" point of view. It may be—and some parts of this book suggest that it is likely—that research is going on at such a pace that Dr. Rogers may feel the same way about the present book in a few years.

The volume is divided into three parts: *A Current View of Client-Centered Therapy*; *The Application of Client-Centered Therapy*; and *Implications for Psychological Theory*. The first part presents the heart of this type of therapy. It is documented with frequent excerpts from interviews, with material written by clients about their experiences, and by research findings. Some of the research has appeared in journals during the past nine years, some is from unpublished theses, and some is presented for the first time. When one considers the difficulty of evaluating counseling and therapy, the efforts of some of the students who have done the research presented seem truly noteworthy.

Part II of the book contains a chapter on play therapy contributed by Miss Elaine Dorfman; a chapter on group-centered psychotherapy contributed by Dr. Nicholas Hobbs; and a chapter on group-centered leadership and administration by Dr. Thomas Gordon. Two other chapters in this part are written by Dr. Rogers and are concerned with student-centered teaching and the training of counselors and therapists. All of these chapters are documented by research and excerpts from actual interviews and group situations.

The third part of the volume is an expansion and elaboration of the theory of personality that Dr. Rogers presented in the September, 1947, issue of *The American Psychologist*.

The book is suitable for classroom use in that there is appended to each chapter a list of suggested readings; there is a bibliography of

two hundred and twenty-eight references; and an excellent and very complete index.

Dr. Rogers and the contributors present their material refreshingly and objectively. There is no rigid attempt to convince the reader that "this is it." They present their evidence and findings and at the same time point out their shortcomings and lack of evidence. The most common objections of critics of this type of therapy are presented, together with explanations of the client-centered therapist's stand.

It is this reviewer's judgment that this book is a "must" for any one interested in counseling and therapy. Part III and some portions of Part I are particularly provocative. This reviewer suggests that it would be interesting and stimulating for several friends to read the volume concurrently and discuss it as they do so. Several parts of it have philosophical implications which bear reading and rereading.

JOHN L. WALKER

Mount Vernon, New York

NOTES AND COMMENTS

ANNUAL MEETING OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

The National Association for Mental Health held its Second Annual Meeting in New York City, November 17, 18, and 19. The general sessions and special meetings took place at the Henry Hudson Hotel, the annual dinner at the Hotel Biltmore. Two hundred and fifty delegates from state and local mental-hygiene societies attended the meeting. The attendance at the dinner was 400, including members and guests.

The first session was given up to reports on some basic activities in the mental-health field. Dr. Harold W. Elley, Chairman of the Board of Directors of The National Association for Mental Health, presided. Dr. William Malamud, of Boston, Director of the Association's Committee on Research in Dementia Praecox, spoke on "Developments in Research";¹ Dr. George S. Stevenson, Medical Director of the Association, on "Training in Psychiatric Disciplines";² and a paper by Mr. Raymond G. Fuller, Director of the Association's Study of Administration of State Psychiatric Services, was presented by Mrs. Ethel Ginsburg, Mr. Fuller being unable to be present.

At the luncheon that followed, Dr. Thomas A. C. Rennie, of the Professional Committee of the National Association's Board of Directors, spoke on "Looking Ahead in Mental Health."

The afternoon was taken up with regional conferences of delegate members and the annual business meeting of the National Association. In the evening there was a preview of some new mental-health films.

"Building a Citizens Movement" was the theme of the first session on November 18. The Reverend Waldemar Argow, of Cedar Rapids, Iowa, a board member of the National Association, acted as chairman. Factors common to all health and welfare agencies were discussed in two papers: "Determining Program in Voluntary Health and Welfare Agencies" by Leonard Mayo, Director of the Association for the Aid of Crippled Children, and "Common Factors in Building Understanding and Broadening the Base of Citizen Participation in Health and Welfare Organizations," by Sallie Bright, Executive Director of the National Publicity Council.³ The

¹ For this paper see pages 14-21 of this issue of *MENTAL HYGIENE*.

² For this paper see pages 22-29 of this issue of *MENTAL HYGIENE*.

³ For this paper see pages 30-35 of this issue of *MENTAL HYGIENE*.

relation of these factors to the mental-health field was then taken up in a panel discussion led by Mrs. Eli Golden, board member of the Mental Hygiene Society of Maryland; Mrs. Frank Little, President of the Oklahoma Association for Mental Health; and Mrs. Hal Short, First Vice President of the Mental Health Association of Oregon.

Two special luncheons followed: one on "Planning and Organizing for Social Action," David Bouterse, Executive Director of Pennsylvania Mental Health, Inc., acting as moderator; the other on "Community Interest in World Mental Health Activities," moderator, Dr. Frank Fremont-Smith, Medical Director of the Josiah Macy, Jr. Foundation.

The afternoon session was on "Some Special Areas for Development in Program for 1953," Mrs. Ralph Henderson, Vice President of the New York State Society for Mental Health, acting as chairman. The discussion was led by Marian McBee, Director of Field Service of The National Association for Mental Health, and Dr. Margaret Ross, Director of the New York State Society for Mental Health. Improved services for the mentally ill and the emotionally disturbed, the prevention of mental handicaps, and the promotion of mental health were among the subjects considered.

At the opening session on Wednesday morning, Robert M. Heininger, Acting Executive Director of The National Association for Mental Health, discussed plans for the 1953 campaign. Mr. Heininger also acted as discussion leader at a workshop on fund-raising that followed. Another workshop—on perspectives in mental-health education—under the chairmanship of Dr. E. S. Watson of Brookings, South Dakota, a board member of The National Association for Mental Health, took up the question of Mental Health Week, presenting some of the high lights of 1952 and considering steps for consolidating gains in 1953.

The final session, under the chairmanship of Dr. Elley, was on the theme, "Realizing Our Goals for Mental Health in 1953." Dr. Shirley Star, of the National Opinion Research Center, presented a paper on "What the Public Thinks About Mental Health and Mental Illness." This was followed by a discussion on "The Meaning of This for Mental Health Associations," led by Dr. Warren Brown, of Houston, Texas, a board member.

The session also considered the subject of "Working Together in 1953." Three points of view were presented—the local association's by the Reverend Jack Mendelsohn, of the Winnebago County Mental Health Society, Rockford, Illinois; the state association's, by Charles H. Frazier, President of Pennsylvania Mental Health, Inc., Philadelphia; and the national association's by Harry E. May-

nard, Secretary of The National Association for Mental Health. A final summing up was made by Robert M. Heininger.

The program of the annual dinner meeting—held on the evening of the 19th with Dr. Elley presiding—included brief addresses by Dr. John Rees, Director of the World Federation for Mental Health; Lady Norman, J.P., Vice Chairman of the National Association for Mental Health of Great Britain; and Mary Jane Ward, author of *The Snake Pit*. Another feature of the evening was a presentation of the American Theatre Wing production, *My Name Is Legion*, a drama based on the life of Clifford W. Beers, founder of the mental-hygiene movement.

The National Association for Mental Health gratefully acknowledges the coöperation of the New York State Society for Mental Health in the arrangement of this program.

THE FIFTH INTERNATIONAL CONGRESS ON MENTAL HEALTH

The World Federation for Mental Health has accepted the invitation of the Canadian Mental Health Association and the Canadian Psychological Association to hold the Fifth International Congress on Mental Health in Toronto, Canada, August 14–21, 1954.

The World Federation for Mental Health was created in 1948, to promote better human relations and to increase understanding among cultures, among nations, and among professions. It is the only voluntary international organization of its kind so broadly conceived. The federation grew out of and replaced an older body known as the International Committee for Mental Hygiene. By creating a body with a new name, it was hoped to express a broad conception of inter-disciplinary partnership in human relations rather than to lay primary stress on mental illness, and to emphasize the fundamental importance of planning for preventive work.

The federation has consultative status with U.N.E.S.C.O. and the World Health Organization and is on the register of the Secretary-General of the United Nations as a body to be consulted by the Economic and Social Council.

The members of the federation are mental-health associations and professional societies. These cover the major fields concerned with mental health, human relations, and intercultural understanding, and include medicine, psychiatry, psychology, cultural anthropology, sociology and social work, education, and nursing. There are 72 member societies from 38 countries and the total number of technically trained people who are members of these associations of the federation approximates 1,000,000. Many individuals are also affiliated with the federation as associates.

Four International Congresses have been held to date. The first

two—in Washington in 1930 and in Paris in 1937—were under the auspices of the International Committee on Mental Hygiene. The Third Congress, held in London in 1948, had as its theme "Mental Health and World Citizenship." It was out of this congress that the World Federation for Mental Health developed. Since that time the federation has held annual meetings in Geneva, Paris, Mexico City, and Brussels. The Fourth International Congress on Mental Health was held in Mexico City on December, 1951.

The Fifth International Congress is to be held at the University of Toronto, August 14-21, 1954. The program of the congress is being planned to reflect advances in the mental-health field, and to assist in realistic planning for the future. The congress theme is: Mental Health in Public Affairs.

Inquiries about the congress should be sent to The Executive Officer, Fifth International Congress on Mental Health, 111 St. George St., Toronto, Canada.

FELLOWSHIPS IN CHILD PSYCHIATRY AVAILABLE

Fellowships offering specialized training in child psychiatry are available in a number of member clinics of the American Association of Psychiatric Clinics for Children which have been approved as training centers by the association. *The training begins at a third-year, postgraduate level, with minimum prerequisites of graduation from medical school, a general or rotating internship, and a two-year residency in psychiatry—all approved.* The majority of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

This training is in preparation for specialization in child psychiatry, and especially for positions in community clinics devoted wholly or in part to the outpatient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction in therapeutic techniques with children in outpatient settings which utilize the integrated services of the psychiatric-clinic team. Most of the clinics have a two-year training period, although a few will consider giving one-year training in special cases.

Fellowship stipends are usually in line with U. S. Public Health Service standards—that is, approximately \$3,600—as these stipends come mainly from the Public Health Service. Stipends sometimes are paid by state departments of mental health, individual clinics, and occasionally communities, paying for the training of psychiatrists who engage to work in these communities at the end of their training. Special arrangements may be made occasionally to supplement

the stipends by taking on other responsibilities locally (*e.g.*, part-time work with the Veterans Administration, consultation to social agencies, and so on). A limited number of training centers can offer higher stipends.

The office of the American Association of Psychiatric Clinics for Children acts as a clearing house for applicants. Application may be made through this office or directly to the individual clinics. In all cases, acceptance of applicants for training is by the individual training centers.

For further information and for application forms, write to: Miss Marion A. Wagner, Administrative Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, New York.

**UNIFORM DATA ON PSYCHIATRIC-CLINIC OUTPATIENT SERVICES TO BE
COLLECTED BY NATIONAL INSTITUTE OF MENTAL HEALTH**

In an effort to meet the need for nation-wide statistical information on psychiatric-clinic outpatient services, the National Institute of Mental Health, in consultation with interested groups, is developing a preliminary report form for the annual collection of data in this field. Such information is unavailable at the present time.

It is hoped that the collection of uniform data in this area will provide basic information to state, local, federal, and voluntary groups interested in mental-health services, as well as helping communities determine what additional mental-health facilities they may require.

The basic facts to be sought by the institute will cover the geographic areas served; the hours per week that the clinic is open; the number, age, sex, and diagnoses of persons served and the amount of service received; community services; professional staff members and trainees; and budget and source of funds.

Present plans are to distribute the revised forms and instructions early in 1953, in order to have a nation-wide report initiated for the fiscal year 1954.

A preliminary draft of the reporting form has been distributed for comment and suggestions to all state mental-health authorities and to national organizations. The National Institute of Mental Health would greatly appreciate comments from all organizations that are concerned with child or adult mental-hygiene-clinic services, or from professional groups engaged in these or allied activities. It is hoped that the comments and suggestions resulting from the critical review of the preliminary report forms by so many interested groups will facilitate the development of a form that will be practical and yet serve the needs of participants. Interested

groups that have not received a copy of the preliminary report form should direct requests for the report forms to Dr. Morton Kramer, Chief, Biometrics Branch, National Institute of Mental Health, Bethesda 14, Maryland.

VETERANS ADMINISTRATION OFFERS COURSE IN PSYCHIATRY AND NEUROLOGY

The Veterans Administration is instituting a four-month intensive training course in psychiatry and neurology to fit the needs of physicians without such previous training who are assigned to duty in 22 predominantly psychiatric hospitals. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

The course will be held at the Veterans Administration hospitals in Coatesville, Pennsylvania, and Palo Alto, California, with a joint Downey-Hines, Illinois, program near Chicago. Physicians will be employed at salaries commensurate with their training and experience (salary range: \$5,500 to \$11,800 per annum) and assigned to the course with travel and per diem for the four-month period.

Information and applications may be obtained from your nearest Veterans Administration hospital or regional office, or by writing to the Chief Medical Director, Veterans Administration Central Office, Washington 25, D. C.

UNIVERSITY OF PENNSYLVANIA OFFERS ANNUAL COURSE IN FAMILY LIVING AND SEX EDUCATION

The eleventh annual course in Family Living and Sex Education, given at the University of Pennsylvania, is scheduled to begin on June 29 and to end on July 31, 1953. The course is sponsored by the University of Pennsylvania, and is given in coöperation with the Division of Medical Services, School District of Philadelphia; the Public Health Service, Federal Security Agency; the Pennsylvania State Department of Health; and the American Social Hygiene Association. It is intended for public-health workers, counselors, teachers, religious leaders, nurses, social workers, group leaders, and parents.

The faculty consists of fifty distinguished teachers and lecturers, including Dr. Frederick H. Allen, Director of the Child Guidance Clinic of Philadelphia; James H. S. Bossard, professor of sociology and Director of the Carter Foundation, University of Pennsylvania; Dr. Norman R. Ingraham, Commissioner of Health of Philadelphia; and Dr. John H. Stokes, professor emeritus of the Medical School, University of Pennsylvania.

Dr. Norman R. Ingraham is the director of the course, with offices at 215 South 34th Street, Philadelphia 4, Pa. A limited number of scholarships covering tuition are available upon request.

**FORD FOUNDATION MAKES GRANT FOR RESEARCH IN
JUVENILE DELINQUENCY**

A grant of \$200,000 has been made by the Ford Foundation to the Harvard Law School in support of the researches into the causes and treatment of juvenile delinquency conducted under the direction of Professor Sheldon Glueck and his wife, Dr. Eleanor T. Glueck.

In announcing the grant, Dean Griswold, of Harvard Law School, said: "The Ford Foundation grant will enable the Gluecks to accelerate the development and validation of their diagnostic tests designed to reveal early tendencies to delinquency in children. If the tests are as successful as initial studies give promise, preventive and remedial measures can be taken while the children having these tendencies are still young enough to respond readily to treatment."

The grant was made by the Ford Foundation under a mandate of its trustees to support, as part of its over-all program, "scientific activities designed to increase knowledge of factors which influence or determine human conduct, and to extend such knowledge for the maximum benefit of individuals and of society."

**SCHOOL OF APPLIED SOCIAL SCIENCES AT WESTERN RESERVE
UNIVERSITY GETS GRANT OF \$50,700**

A grant of \$50,700 has been made by the Russell Sage Foundation to the School of Applied Social Sciences at Western Reserve University, Cleveland, Ohio. The fund will be used for a program to enrich the present curriculum at the School of Applied Social Sciences through closer relation of the social sciences to the practice of social work. The school will now be able to add a social scientist to its full-time faculty for an initial period of three years. Holding the rank of visiting professor of social science, the additional staff member will be a teacher and consultant both in the regular master's program and on the doctoral level. The main function of the visiting expert will be to introduce into the applied-social-science curriculum current material and points of view from related social sciences, such as cultural anthropology, social psychology, political science, and economics.

The new program at Western Reserve is scheduled to begin when the fall semester opens in September, 1953. Funds from the foundation will be given to the university over a three-year period.

Dr. Grace L. Coyle, professor of social group work at the School

of Applied Social Sciences, has been named by Dean Margaret Johnson to head the faculty committee that will work with the visiting professor in setting up the special program.

ASSOCIATION FOR THE EDUCATION OF THE MENTALLY HANDICAPPED CHILD GETS LANE BRYANT ANNUAL AWARD

The Association for the Education of the Mentally Handicapped Child, of Milwaukee, Wisconsin, has been awarded the One Thousand Dollar Lane Bryant Annual Award for 1951, in recognition of outstanding volunteer service to their community. The presentation was made on November 17, at a luncheon at the Hotel Plaza, New York City, by Raphael Malsin, President of Lane Bryant, Inc., before a group of 300 leaders in social welfare, civic, educational, business, and publishing fields.

The Association for the Education of the Mentally Handicapped Child is a group of parents who started a school for their own mentally retarded children, a school focusing not only on scholastic education, but on recreation and social development as well. They were recognized by the Lane Bryant Annual Award for their success in proving that such children are educable, in persuading their school board to inaugurate special classes for retarded children, and in influencing the state legislature to vote financial support of public education for them.

This is the fourth annual award given by the Lane Bryant Company, which established the award in 1948.

FAMILY SERVICE SPREADING HELP TO FAMILIES THROUGH OTHER COMMUNITY SERVICES

Increasingly, family-service agencies are providing professional assistance to people and families "with a problem," not only within the doors of the agencies, but through the facilities of other community organizations.

This trend toward extending counseling services through direct coöperation between family-service and other health and welfare agencies in a community was revealed in a study, by Information Service of the Family Service Association of America, of the special services offered in 1951 by the association's 250 member agencies in some 200 cities. Last year the affiliate agencies of the association joined with 181 other community agencies in providing special case-work services. This compares with 108 such coöperative special services provided by association members in 1949, an increase of 68 per cent.

The largest group of agencies with which Family Service worked to bring help nearer to the people needing it were children's agen-

cies—camps, day nurseries, and children's homes—but they also included health agencies, such as clinics and hospitals; group-work agencies, such as Y.W.C.A.'s and settlement houses; homes for the aged; and homes for unmarried mothers.

Besides these joint efforts in 1951, the family-service agencies in the association provided a considerable number of special services on their own. Some 85 agencies helped place children in foster or adoptive homes; 17 agencies maintained health services, such as dental or medical clinics or nursing services; more than 50 agencies provided "homemaker services," placing a trained home manager in a family when a parent was temporarily hospitalized or otherwise absent. Eighteen agencies had facilities for legal aid to persons who needed this help in addition to family counseling; 36 agencies offered such other special services as programs for the aged, help to immigrants or the blind, and family-life education. In addition, 36 agencies operated institutions such as camps, children's homes, nurseries, or homes for oldsters.

The special services provided *within* agencies in 1951, however, showed only a slight increase over 1949 as compared with the strong movement toward extension of help to families through other community programs.

INPATIENT PSYCHIATRIC SERVICE FOR CHILDREN OPENED AT UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

In October an inpatient psychiatric service for children was opened at the University of Minnesota Medical School and Hospitals. This new unit will materially strengthen the over-all child-psychiatry program of teaching, research, and service that has been in operation since 1938. Expansion of the program was made possible by a legislative appropriation, which also provided for increased staff and stipends for training in child psychiatry. A position as instructor is available for a qualified physician desiring an academic career. Those interested should contact Reynold A. Jensen, M.D., University of Minnesota Hospitals, Minneapolis, Minnesota.

DISCUSSION MEETINGS FOR FOSTER PARENTS

The special nature of many problems faced by foster parents who provide boarding care for children temporarily away from their own homes has been disclosed in a unique, state-wide program sponsored by the State Charities Aid Association of New York, which has just reported on the program's first year of operation.

The program was built around discussion meetings at which foster parents, under trained leadership, talked about the problems confronting them. The association also announced the publication of

a booklet, *Step by Step*, for the guidance of lay and professional groups who are interested in holding similar meetings to help foster parents in their communities.

During the year, the association reports, 54 such meetings were held in 17 communities of the state, with a total attendance of more than 2,500 foster parents. The meetings were arranged by local civic leaders and child-caring agencies, with assistance from the staff of the association's state committee on children and public welfare.

Miss Helen Van O. Kerr, executive secretary of the association's state committee on children and public welfare, said that many additional communities are planning to undertake the program and that by next fall discussion meetings will have been held in about half the counties in the state. The state committee's services are being financed by grants from the Doris Duke Foundation and the Grant Foundation, and will continue for another year.

Typical of the questions asked at the meetings by foster parents, the association reports, was "What can we do to make the child feel more at home in the community of the foster parents?" A typical answer offered by other foster parents was, "Encourage him to join group activities such as the church, Scouts, 4-H, etc., because in group activities he can gain merit on his own and be a part of the community."

Another typical question was, "What can we do when neighbors, playmates, and sometimes even teachers ridicule the foster child because he is not living with his own parents?" One answer was, "I think we should let the community know, through civic and church groups, just how much lasting harm this does to the children." Another foster parent said, "I think if we give the foster child knowledge of being loved and wanted, he will develop a feeling of security and importance in our home so that he will not feel hurt and resentful."

The association reports that many of the situations discussed by the foster parents had to do with behavior problems that are common to all normal phases of childhood and adolescence, but that sometimes seem more serious to the foster parents because the children are not their own. As one foster mother said, "Sometimes when my foster child does something particularly irritating, I feel like calling the case-worker and saying 'Come and get him.' Then I realize that if he were my own child, I would just have to accept it and try to do something about it, so I soon get my perspective back and understand that his behavior was pretty normal for a child his age."

An important result of the program, the association said, has been

to make local communities more conscious of the "fine work foster parents are doing."

The booklet, *Step by Step*, in explaining how local community groups can set up and carry out a series of discussion meetings for foster parents, also lists films, recordings, and pamphlets that are helpful in carrying out the program. It is available at 25 cents a copy from the State Charities Aid Association, a voluntary citizens' organization, at 105 East 22nd Street, New York 10, New York.

DUKE UNIVERSITY PSYCHIATRISTS INVESTIGATING BLACK MAGIC AND HEXES

Duke University psychiatrists now are grappling with "black magic," and "hexing spells" in particular, according to a statement recently issued by the university's bureau of public information.

Dr. Vernon Kinross-Wright, Duke neuropsychiatrist, has urged the Southern Medical Association to take a closer look at black magic and hexes. The majority of hex victims have serious mental illnesses, he declared, but some do not.

For instance, a thirty-two-year-old man recently came to Duke Hospital suffering from gripping pains in his stomach. He couldn't eat, and his thirst was excessive. He believed that he was intended to die of starvation, imagining that he had been "spelled" by a local magician for having cheated a partner in a business deal.

He came to Duke because he had heard that the psychiatrists could hypnotize people and "take things off their minds," but he reserved the right to visit a "conjure man" in a nearby city before Duke doctors actually treated him.

"I heard some three weeks later," Dr. Kinross-Wright said, "that the hex has been successfully removed and the patient is in good health."

This man was not a severe mental case and could not be called such, the Duke doctor declared, unless the same label were put on most of his friends and relatives who confirmed the alleged hexing.

"A man who thinks he has been placed under the influence of a spell is not in a normal state," the Duke neuropsychiatrist said. "He must, of course, be highly suggestible and must also have committed some act that makes him feel guilty."

Duke doctors can only try to explain to such patients the absurdity of their beliefs. They cannot throw up their hands in despair and give up trying to understand hex victims. In most cases, the doctor can understand and help if he has enough patience.

Psychiatrists see a very small percentage of hex victims, but, stated Dr. Kinross-Wright, "I know from experience and from what I

have been told by other patients that there are many cases of real or imaginary hexing which go unrecognized." That is, many of these patients go to general doctors with complaints of mental or physical illness, but they do not tell the doctor about the alleged hex and the doctor does not recognize the symptoms. Other victims just go from one conjure man to another, playing a kind of "hex, counter-hex" game.

A twenty-four-year-old man came to Duke Hospital a few years ago complaining of stomach pains and nervous spells during which he nearly choked. He had lost a great deal of weight, having been "bewitched" through a rival suitor. He said the hex was placed upon his well and was working through his drinking water.

"Newspapers got hold of the story and he became a national figure," the Duke doctor recalled. "A New York hypnotist was flown down to see him, unfortunately arriving the day after he had been cured by a local magician.

"For publicity purposes, he was rehexed and cured on the spot by the visiting fireman!

"Modern urban cultures regard those who express such ideas of influence as psychotic," Dr. Kinross-Wright continued. "But cultural change lags far behind, particularly in isolated rural regions in the South, and such ideas are not to be lightly dismissed as crazy."

The healing power of the "counter hex" by a conjure man apparently is so great, Dr. Kinross-Wright told the Southern doctors, that "I do not believe we should reject it as mere mumbo-jumbo.

"Let me urge you to more careful consideration of the meaning of hexing spells. It will promote better understanding of the patient—perhaps preventing unnecessary investigation and treatment."

DR. RODGERS APPOINTED DIRECTOR OF BINGHAMTON STATE HOSPITAL

The appointment of Dr. Arthur G. Rodgers as director of Binghamton State Hospital has been announced by Dr. Newton Bigelow, Commissioner of Mental Hygiene. Dr. Rodgers succeeds Dr. Hugh S. Gregory, retiring director, and will take office January 1. He goes to Binghamton from Central Islip State Hospital, where he has been assistant director since December 1931.

Dr. Rodgers was born in Watervliet in 1892. In 1915 he graduated from Albany Medical College and began internship at Troy Hospital, since named St. Mary's, in Troy. He entered state service at Willard State Hospital in 1916, and the following year became a staff member at Hudson River State Hospital.

From March, 1918, until June 30, 1919, Dr. Rodgers was in military service, a captain in the U. S. Army attached to the 62nd

Division of the British Army serving in France and Belgium, and with the Army of Occupation in Germany. After his war service, he was in private practice in Troy, until, in December, 1921, he joined the medical staff at Veterans Administration hospitals first in Philadelphia and later in New York City. He returned to state service as assistant physician at Hudson River State Hospital, remaining there until his appointment as assistant director of Central Islip State Hospital in 1931.

Dr. Rodgers is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, a fellow of the American Geriatrics Society, and a member of state and local medical societies.

NATIONAL LEAGUE FOR NURSING APPOINTS PSYCHIATRIC NURSING CONSULTANT

Appointment of Kathleen Black, R.N., as Psychiatric Nursing Consultant and Director of the Psychiatric and Mental Health Nursing Project, has been announced by Anna Fillmore, R.N., General Director of the National League for Nursing, of 2 Park Avenue, New York City. In announcing the appointment, Miss Fillmore said:

"In view of the appalling lack, both in numbers and quality, of nurses and attendants prepared to give adequate care to the mentally ill, Miss Black plans to participate in local, state, and national activities aimed at improving the nursing care of psychiatric patients. Upon request, Miss Black will provide consultation, information, and advice to individuals, schools, and other organizations interested in psychiatric nursing. She will also organize and take part in conferences, workshops, and institutes to help nurses and others improve both psychiatric nursing service and educational programs in psychiatric nursing for nurses, attendants, aides, and technicians."

Miss Black's psychiatric nursing experience, extending over more than twenty years, has included service in public and private hospitals in the United States and Canada. She has organized and taught in educational programs for aides, nurses, and basic and graduate students in nursing, having been associated successively with hospitals in Ontario, Canada; Sheppard and Enoch Pratt Hospital, Towson, Maryland; the University of Chicago clinics; the Cook County (Illinois) Psychopathic Hospital; Teachers College, Columbia University; the Menninger Foundation, Topeka, Kansas; and the University of Minnesota School of Nursing.

A graduate of Ontario Hospital, Whitby, Canada, Miss Black received a certificate in teaching and supervision at the University

of Toronto; a B.S. degree in nursing education at the University of Chicago; and an M.A. in nursing education at Teachers College, Columbia University.

AMERICAN SOCIAL HYGIENE ASSOCIATION APPOINTS DIRECTOR

Announcement has been made of the appointment of Conrad Van Hyning as executive director of the American Social Hygiene Association. He succeeds Dr. Walter Clarke, who retired last June after almost forty years with the American Social Hygiene Association.

Mr. Van Hyning, formerly general director of the National Travelers Aid Association, has had long experience in various health and welfare agencies. He was director of public welfare for the District of Columbia and was assistant executive director of New York State's Emergency Relief Administration and New York City's Welfare Council. He has taught public welfare and community organization courses at both City College and the New York School of Social Work.

As director of Community War Services in the Caribbean area during World War II, Mr. Van Hyning negotiated with foreign governments and island possessions of the United States to assure satisfactory protection of the health of American service personnel stationed in Puerto Rico, the Virgin Islands, and South America. He also worked with military and civil officials to provide adequate recreation for service men and to prevent the spread of venereal disease.

After the war, Mr. Van Hyning headed U.N.R.R.A.'s welfare division both here and in Europe. Later, he reorganized the displaced-persons program, directed repatriation, and consolidated U.N.R.R.A.'s activities with voluntary and other international agencies.

OFFICERS ELECTED BY THE PENNSYLVANIA PSYCHIATRIC SOCIETY

At the Fourteenth Annual Meeting of the Pennsylvania Psychiatric Society, the following were elected as officers for the year 1952-53: president, Philip Q. Roche, M.D., Philadelphia; president-elect, Frederick H. Allen, M.D., Philadelphia; secretary-treasurer, M. Royden C. Astley, M.D., Philadelphia.

Plans were laid for two new departures in society activity, the first calling for a week-end spring meeting with a well-organized scientific program; and the second providing for all-day consulting sessions, using visiting psychiatrists at various medical centers.

ANNOUNCEMENTS OF MEETINGS

The American Psychosomatic Society has changed the dates of its coming annual meeting. Instead of taking place in May, the meeting

will be held on April 18 and 19, 1953, at Chalfonte-Haddon Hall in Atlantic City.

The American Occupational Therapy Association will hold its Thirty-Sixth Annual Conference, November 13-20, 1953, at the Shamrock Hotel, Houston, Texas.

CURRENT PUBLICATIONS

The first three in a series of booklets on "Realistic Educational Planning for Children with Cerebral Palsy" have just been issued by United Cerebral Palsy as part of its over-all national program for helping the nation's palsied children. Fourteen prominent educators, all of them specialists in the field, have combined their talents as volunteer members of United Cerebral Palsy's educational advisory board to produce the series, which will total nine pamphlets.

Outlining the purpose of the study, the chairman of the educational advisory board, Maurice H. Fouracre, Ph.D., head of the Department of Special Education, Teachers College, Columbia University, New York, states in the preface to the first pamphlet:

"The need of a special educational program for children handicapped by cerebral palsy has become increasingly evident during the past two decades. Medical research has revealed that these brain-injured children present unique problems in development, learning, and adjustment. Planning to meet their educational needs requires knowledge and training beyond that utilized in working with children with orthopedic handicaps which do not involve the central nervous system.

"The purpose in preparing this pamphlet, 'Realistic Educational Planning for Children with Cerebral Palsy,' has been to make available the experience and thinking of professional workers in this field of education in response to the growing demand for information and guidance in setting up educational programs for these children. This is the introduction to a series of brochures, each dealing with one specific phase of the program in greater detail."

In the foreword to this pamphlet, Leonard H. Goldenson, President of United Cerebral Palsy, praises the work of the volunteer educational board as a "monumental accomplishment," and points out that the study is "unlimited as to age periods, and the authors have wisely considered the educational problem from the earliest impressionable years up to college for those of college caliber."

The philosophy of education for children with cerebral palsy and the important preliminary steps to be taken are treated in Pamphlet No. 1 of the series.

Pamphlet No. 2 deals with the pre-elementary-school level, and No. 3 of the series covers specialized problems of the elementary-

school level. Additional pamphlets will deal with six other special phases: mentally handicapped children with cerebral palsy, secondary-school level, college level, psychological evaluation and counseling, speech therapy, and teacher training.

Copies of these pamphlets are available, without charge, for libraries, schools, teachers, and professional personnel concerned in the education of the cerebral palsied. Requests should be addressed to Dr. Maurice H. Fouracre, United Cerebral Palsy, 50 West 57th Street, New York 19, N. Y.

CURRENT BIBLIOGRAPHY *

Compiled by

EVA E. HAWKINS

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THE DEAN AND THE PSYCHIATRIST: A SYMPOSIUM

AT the Thirty-fourth Annual Meeting of the National Association of Student Personnel Administrators held at Colorado Springs, Colorado, in April, 1952, the general theme of the conference was, "How Can We Effectively Develop a Sense of Higher Standards of Personal Integrity and Individual Responsibility in the University and College Community?" The association is made up of deans of major colleges and universities throughout the United States, and they brought to the discussion of this topic a wide variety of convictions and experience, all testifying to its importance.

Of particular significance to mental hygiene was the fact that one half-day session, and parts of others, were devoted to the mutual problems encountered by deans and psychiatrists as they work toward the improvement of the educational environment in their various institutions. The four papers that follow are based, in large part, on discussions given before that group. Though diverse in origin, they illustrate a common point of view that is gradually developing in American colleges toward the mental-health problems of college students, and the educational methods that may be used to meet them.

THE DEAN AND THE PSYCHIATRIST

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A DEAN, by origin and tradition, is an ecclesiastical official connected with a cathedral of the Church of England. He is subordinate to the bishop, whose energies are more properly reserved for spiritual concerns. The dean is re-

sponsible for the fabric of the cathedral, for the proper conduct of ritual, for the relation of the cathedral to the immediate community, and for all the agencies through which the spiritual authority of the bishop is expressed. Occasionally, in the absence of the bishop, he rises to high spiritual themes, and may even preach the sermon. He should be capable of this, without seeming to be too obviously absorbed in material and mechanical details.

It was a natural historical development that colleges and universities should have taken over much of ecclesiastical organization, and as long as their purposes were fundamentally religious, the analogy between the president and the bishop, the dean of the college and the dean of the cathedral, was fairly close. In so far as the college dean is a traditionalist he is a symbol of authority that comes from above. He represents the ideals of our Puritan forefathers, of the religious organizations that have maintained so many colleges in this country, of the established communities in which the colleges are situated, of the parents who wish their children to assume their proper place in a well-ordered society, and of alumni who have grateful memories of the dear old dean who rebuked them sternly, but lovingly, when a boy and a girl rode recklessly down the campus hill together, two on a sled.

Intellectually, the dean's traditions are with the faculty. He has usually gone through the selective processes of the Ph.D.; he is acquainted with research; he knows the pride of a department in its successful students in the graduate schools; he has usually taught long enough and well enough to be treated with kindly condescension about his lapse into administration. He may descend from philosophy or engineering, literature or physics. He has been selected for personal qualities rather than professional training. He has strong sympathies with the faculty in their belief that intellectual training is the first purpose of the college, and that disturbing elements in student life are to be taken into account if and when they seem to interfere with the work of the intellect.

But the dean is a strong character if he can long observe students, parents, and alumni and maintain his faith that the college produces its chief effect through the intellect. Whatever his creed, he must stand up to all the questions of the

critics of the college. Why has this Utopia, this Garden of Eden, where only well-qualified students are permitted to enter, where carefully trained teachers pour out knowledge and learning, where the wisdom of the ages is available in libraries—why has this Utopia allowed the serpent to enter? Why do so many students resist everything but temptation? Why do they offend their elders by bad taste, bad dress, vulgar displays of affection, insolent defiance of long-cherished beliefs, strange and hot radicalisms, violent assertions of independence, impatience with all distinctions of class and caste, race and religion? Why do so many in their private lives seem so full of divided aims, hesitant purposes, insomnia, and youthful melancholy?

Some deans will find the answer to all this in the decay of traditions, in the loss of moral fiber, the decline in parental responsibility, the paternalism of government, and the general state of the world which youth is about to inherit; they will strengthen their public exhortations, stiffen their rules, and call for a revival of religion. All this will naturally raise questions about the responsibility of the dean for morals and morale. These responsibilities are the subject of troubled discussion at "deans" meetings, and from many questionnaires have evolved many papers on the fifty-four duties of the dean. For the purpose of this discussion we shall include only his inevitably moral duties of selecting students, advising them, and rewarding and punishing them.

The dean's office is ultimately responsible for administering whatever admissions policies are agreed upon by the board of trustees, the faculty, and the administration. The college standards of work and conduct are probably more largely determined by the character of the students accepted for entrance than by rules or requirements imposed afterward.

After the student has begun his college career, the dean's office attempts to organize the advice, the rewards, or the punishments bestowed upon him according to his condition. The first advice is likely to concern the selection of courses, their relation to his widening intellectual horizon, and to his possible future profession. Later he may be troubled by mistakes in his first choice of courses, by failure to achieve satisfactory grades, by difficulties in human relations, by problems in the selection of activities for participation in com-

munity life, and by changing ideas about the choice of a career. Much of the advice of the dean's office also concerns organizations and rules. The dean is concerned with faculty rules, house rules, fraternity regulations, constitutions for social and political organizations, literary and artistic groups, and the increasingly powerful student government.

Students who have been conspicuously successful in this closely knit academic and community life are rewarded with membership in various honor societies, with inclusion in deans' lists, with special awards and prizes, with scholarships according to their achievements, their needs, and the college resources, and with reasonably accurate and complete recommendations to graduate schools, to future employers, and to the F.B.I. Students who are unsuccessful in their work, their human relations, or whose conduct is unacceptable, are advised or warned, put on probation, and, when necessary, dropped. Their records and recommendations constitute a special difficulty in presenting a truthful account which allows for adolescent changes and future possibilities.

It is obvious that great differences of spirit may prevail in these processes of admitting, advising, rewarding, and punishing. It is still possible, perhaps, for an authoritarian personality to dominate all these situations with the strength of his convictions, especially if he has a small, closely knit community supporting him. But the authoritarian dean is becoming more and more of an anachronism. All policies for admitting, advising, rewarding, and punishing are highly controversial, are profoundly influenced by climates of opinion, by conflicting human values, and by the democratic belief in general community participation.

The admissions policies and procedures, for instance, are the subject of continuous debate at educational meetings of school principals, headmasters, college presidents and admissions officers, testing authorities, and national groups for fighting discrimination. There are also the constant unofficial criticisms from parents and alumni. The general theories, the administrative processes, and the results are subject to continuous examination.

Student advising is now the subject of an extensive literature. The faculty advisers appointed by the dean are criticized as not knowing enough beyond the confines of their

own specialty, as insufficiently interested in their students, as overworked by their own teaching and research, as in general doing an indifferent and amateurish job in a situation that calls for professional training. Students ask to be included among the advisers, and in some cases have been conspicuously successful. Subdivisions in guidance counseling appear, as, for instance, the academic counselor, the personnel worker, and the vocational-guidance expert, the speech and remedial-reading clinicians; and there are here, of course, the usual dangers of over-specialization.

The methods of recognizing and rewarding the successful, which would seem to be the easy and grateful part of a dean's concerns, have their complications, too. The dean's list is assailed as producing too much academic competition, as having a frustrating effect on those not so-recognized. Honorary organizations have their standards and their usefulness assailed. Students dare not wear their medals, and there are revolts against keys of all sorts. Honors once highly prized are viewed with amusement by the next generation, and a new consideration is given to the effect of honors on the unhonored.

Probably the greatest changes have occurred in the area of punishment, or the enforcement of rules. The regulations to be enforced change with such rapidity that students like to publish rule books with humorous footnote references to the quaint and absurd ideas of ten years ago. It is a little difficult to evade the implication that time will soon make to-day's rules quaint and absurd, and there will always be students to insist that the college is a full generation behind the times.

Not only do the rules change, but attitudes toward violators change. Even the college freshman is very sophisticated psychologically to-day, if only as a result of news-stand articles, and he is much more interested in why a rule or custom has been violated than in what is to be done about it.

"Why shouldn't he get drunk?" he asks indignantly. "His father wants him to study medicine!"

The dean may be the chairman of the disciplinary committee, but the students are well represented and they are likely to challenge any rule and to explore sympathetically and philosophically every motive for violating it.

In all the principal functions the dean is asked to perform, the authority of tradition is questioned, the authoritarian per-

sonality arouses revolt, the democratic method compels careful consideration of conflicting views of different elements of the college constituency, and the problems have to be solved in the light of a scientific, but sympathetic comprehension of human behavior.

If the dean had been appointed as a trained psychologist, he might take all this as a matter of course, but he still retains many of the characteristics of the constituency that appointed him. He is very likely to see his problems as arising from a wicked failure of the students to conform to rules of conduct based on experience, reason, and religion. He is prone to view the offender with righteous indignation; if the sinner only would, he could examine his mind and conduct with his reason, and change himself by using his will.

It is this conviction about the power of the will that makes him scrutinize with care the psychological approach. The psychiatrist, he has heard, has a naturalistic view of human behavior; he has been accused of being more concerned with biological origins than with ideal destinies. He may explain why a student acts as he does, but he seems very slow in bringing about decisive reforms; his theories of the unconscious seem to undermine his faith in the freedom of the will; what place is there in the psychiatrist's technique for looking a student in the eye and telling him that he can and must straighten up immediately? If a distinguished psychiatrist can be quoted as saying that the best wisdom for living is to be found in the Sermon on the Mount, there would seem to be no reason why a dean should not quote and apply that source of wisdom as occasion arises, and do it after his own manner.

But here our dean has some qualms. He has often felt that he was attempting some degree of control over a generation that does not speak his language; he has even come to wonder if the Sermon on the Mount is outdated. If the psychiatrists are now taking it up, he thinks, it may be that they have some new manner of applying it. He has loved to quote the Sermon as a means of bringing about a conviction of sin. He has laid it on from above, with a demand for repentance. But he understands that psychiatrists, within the limits of their science, do not apply anything from above.

Apparently the method is to gain as complete an understanding of the individual as possible, and lead him to an insight that grows out of his own experience. As old as Socrates, he thinks. But this, perhaps, is the meaning of a new phrase that he has not quite understood—the progress from authority to therapy. Perhaps it is not so much abandoning ancient values as abandoning the methods of enforcing them. Perhaps these values would be espoused anew by each generation with less revolt if they grew out of a more complete and understanding interpretation of experience. Here is a basis for coöperation with the psychiatrist and it is not a surrendering of values, but a turning to a student of the bases of human nature for more effective techniques of realizing ideals.

With what he hopes is a new insight, the dean reviews his work to see where the advice of the psychiatrist would be most useful. If such a consultant were added to the regular health staff, he could be available to advise the dean informally on many questions of policy and practice. He might meet with faculty and student advisers, with the disciplinary committees, with committees on admissions, and he might lecture to groups of students as well as handling individual cases.

In the admissions process, the questions that the schools answer least satisfactorily about their candidates concern emotional stability. In many cases there is no guidance officer trained to give a dependable appraisal. Even in cases where a full, frank, and adequate account is given, the decision is difficult and requires expert advice. A practical guide is the record of the student's activities. Participation in student government, in athletics, in group undertakings generally, is a pretty safe indication of stability, although the increasingly conscious competition for school leadership is producing many young politicos who are early learning the techniques of riding any cause to prominence, and whose egotism make their leadership of questionable social value.

The top-ranking students, who perhaps compensate for their social deficiencies by intellectual achievements, may later serve society more effectively than some students with immediate and striking "command presence." What proportion of such students would contribute most to the mental health of the community? How equate intellectual stimulus with warm human qualities in producing the best educational atmosphere?

Beyond this, there are always the "queers" and the "creeps" among the applicants, the brilliant rebels against curricular requirements, social conventions, and all current mores. How many of them are helpful in counterbalancing the pressures for community conformity? How many of them would really be benefited by a college experience, how many would benefit the college, and how many would break down and have to be sent away?

These questions are most sanely answered in the give-and-take of committee discussion, but the advice of the psychiatrist would be helpful both in general policies and in individual cases, in advising on the techniques of interviewing, in collecting and interpreting case histories, in bringing to light significant family relationships, and in resisting the pressures to accept unstable individuals at too great a price to the community.

In turning to the advisory functions of the dean, the extensive literature on the subject makes it unnecessary to do more than recount some of the experiences that led one dean to the conviction that the advisers themselves need more expert advice.

Starting with elementary routine, faculty members report at mid-term the students who are failing in their work, or who seem to be dangerously low—frequently with illuminating comments. These lists will usually include about one-fourth of the entering student enrollment as having serious difficulties with from one to three or four subjects. The list is studied in the light of secondary-school records and aptitude scores made in the college-entrance-board examinations, and it is usual to find that well over half of these students have superior ability. The search for causes of failure proceeds through teachers, faculty, and student advisers, dormitory proctors, athletic coaches, and culminates in conferences with the student himself. The record of low academic standing brings with it all sorts of problems, extending far back into the student's past, and affecting all his human relationships.

There are the students who are struggling against parental pressures toward particular professions, frequently medicine, law, or engineering. Others have no profession in mind, but have little interest in studying anything unless they can see immediately where it will get them. With such students, early

vocational motivation seems to be a necessity. A curriculum designed to explore various areas of knowledge has no appeal to them, but if tests can show them an unsuspected aptitude, they will follow the clue contentedly and often energetically. Others may have developed an enthusiasm for the laboratory along with the pleasures of tinkering with the radio and the family car. This, however, often proves to be only a passing phase of their development, and with a loss of interest in laboratory science goes a loss of security in a job, and the readjustment is painful.

The shocks incurred in courses in philosophy, psychology, and literature, which are often discussed as serious intellectual difficulties, are not usually upsetting unless there has been a disturbed personality before, but the students who assign their disturbances to philosophical ideas have to be met on the intellectual level; they often deeply resent any suggestion that their past development needs to be examined psychologically. If they must give up their early quest for certainty, a whole new motivation must be established to support any quest at all.

The young writers very frequently have academic difficulties. They often view the curriculum as furnishing either models or materials for creative writing. They expect to transform any material they absorb into their artistic creations; any knowledge that does not seem to have such possibilities they reject. Examinations are inflexible, objective, and repellent; they ask themselves whether a college degree is worth such martyrdom. Their unhappiness is often increased by a sense of loneliness and isolation. They have a contempt for many of the interests and activities of their classmates, but feel their own lack of participation as keenly as if they really wanted to be presidents of fraternities.

Youthful melancholy and depression are especially common among the exceptionally able students. It would require a treatise the length of Burton's seventeenth-century *Anatomy of Melancholy* to discuss their causes adequately. A few examples will illustrate the problems that come to the dean's office. A boy who thought he came to college to construct a theory of the universe hastily concluded that his courses were irrelevant and left college in despair. A very able student with A and B grades thought that his professors were in a

conspiracy to fool him, and that they would tell him the bitter truth about his lack of ability just before time for graduation. A student who felt his loneliness heightened by the hurly-burly of dormitory life and the gaiety of college dances withdrew to build himself a den and workshop in his father's barn. The lad who had a passionate desire for all experience, and who could not carry out his devotion to the fine arts because of his anxiety about his neglect of physics, had to be hospitalized. An able young scientist, over-conscientious about his work, was seized with a feeling that he was not worth his space in the laboratory. The feeling became so acute that he went to the infirmary, drank poison, and went to the dean's office to tell him that he wouldn't be in the way any more. Luckily the stomach pump was successful. A girl involved in a triangle eliminated herself by jumping in front of a train just after she finished reading *Anna Karenina*. Such cases seem to be adolescent problems of college life, but they all have their roots in childhood years. These students usually regard themselves as unique and misunderstood; they could gain much from a general study of the bases of personality, and from the individual help of the psychiatrist.

A much larger group of students, with more fighting spirit, express their rebellions, repressions, and frustrations through a fierce determination to reform the world immediately. Most of these students come from comfortable and prosperous backgrounds, and very often from homes in which one or both the parents have achieved a conspicuously successful place in society. Literature, of course, is full of examples of dominating parents and rebellious children, but writers usually manage their conflicts artfully and dramatically enough to make a somewhat tragic ending seem inevitable. They also, perhaps unintentionally, give the impression that these are exceptional cases. Only one who has followed some such routine as interviewing parents and children before college entrance and during the college years has an idea of the amount of pent-up rebellion against fathers and mothers, and can understand the attractiveness of any ideas that justify the individual in revolt.

Many of these students when at home have had to suffer in silent resentment. In college they form their opinions in the company of their own age and, confident of support, they

suddenly become highly articulate. The parents then wonder what the college is teaching and what their children are allowed to read. An angry father came to the college to complain that his son was showing an interest in Communist literature; he admitted that the boy had been a natural rebel from an early age, that he had seemed to hate all the conventions of the circles in which the family moved, that he had been unwilling to spend a summer at home since he was fifteen, that he had rebelled against every boss in every job and against all the officers in the army, but the father wanted to start an investigation of the boy's major department to find out who permitted him to read Karl Marx.

These young leaders of revolt are often outraged if it is suggested that they are seeking compensation for their personal disappointments in the exhilaration of joining mass movements; they will deny this while pouring out a not always unjustifiable scorn upon the "contented cows" of the fraternities, who have found life comfortable enough by conforming to the amenities. They enjoy conspicuously informal dress on formal occasions. They know how to dress in the most sophisticated fashion when they care to do so, and they resent appeals for a greater conformity as mere trivia when the world is so full of injustices that ought to absorb the attention of their elders. It seems merely evading the burning issues of modern life to suggest that a worker for social justice might be more effective if he were well-mannered and well-dressed.

Another challenge to the dean and the constituency he represents comes from the questions that arise regarding the relation of the sexes. A recent student editorial complained that the only advice an administrative officer had about sex was "don't." A mother complained that her daughter had been asked by her teacher to read contemporary novels, but that when a companionate marriage had been experimented with, the couple had been dismissed. It was suggested that the college authorities should either ban all contemporary discussion of sex from the campus, or that advanced ideas, whatever they are, should be officially adopted as the approved practice of the college community.

Students ask the dean if he has read the Kinsey report and what he thinks of it. They ask why the institution of chap-

erona should be continued when it is so easily and constantly escaped. They ask why social life between the sexes should so constantly consist of being herded in large groups when their desire is to be alone in a room together, to listen to records, to discuss books, to get away from small talk, and to share together all their generous ardors. These privileges, some of them say, they have had in their homes with entire approval; why should dormitory rooms—the student homes—be sealed against visitors of the other sex? Why should women have to sign out when men do not? Why should not college men and women be given the wisest possible instruction as to dating and mating, and then be left to take care of their own relationships, with a recognition of their right to be alone when they please? They point to the rules of twenty-five years ago and ask if we shall not be just as ridiculous twenty-five years hence. They quote from cultural anthropology, and ask what eternal sanctions support the Puritan traditions. They express their affections on the springtime campus in a free and casual way, which suggests a complete lack of concern about the presence of others and a pagan lightheartedness about it all.

And yet with all this brave assertion of their entire ability to take care of themselves, they are often deeply troubled. They have not achieved freedom from their possessive instincts, they are hounded by jealousies, and they find that some of the old restrictions have as deep a basis in their instincts as the desires that lead to the new freedom. The flame of idealism burns as brightly as ever, and love does not seem to be love if it does not promise to last forever—"bear it out even to the edge of doom." How can these passionate desires of college years be free from the cold damp of caution and convention and yet lead to the fulfillment of happy and responsible family living? What experiences, or lack of them, can the dean really recommend?

Obviously the questions that must be answered in the course of the counseling processes cover a wide range and demand a combination of common sense with a variety of specialized trainings. In the general coördination of the efforts to apply some collective wisdom to the problems of the student, the dean represents the institutional point of view, but he should

learn a great deal from the psychiatrist about individual patterns of behavior.

Now to turn to the remaining functions of the dean's office—rewarding and punishing. As has been suggested, many of the rewards in college life are in the hands of traditional organizations that are beyond the dean's sphere of influence, although he inevitably has to deal with many of the problems they create. Elections to honorary societies such as Phi Beta Kappa and Sigma Xi are usually in the hands of the faculty, and their awards are probably as just as they ever can be. Students protect themselves very readily from an inferior status, however, and are quick to point out the limitations of the honored scholars with such questions as, "Who would want to belong to that group?" Such questions may be unjustified defensive rationalizations, but they suggest that conspicuous rewards do not compel automatic admiration. The same responses are provoked by deans' lists and distinctions between honors and pass students.

The honors bestowed by the students themselves affect greater numbers and raise some of the same questions. Certain types of elective honorary organizations have flourished with selective practices of refined cruelty, and with traditional mumbo-jumbo ceremonies that now arouse the ridicule of undergraduates. They are being transformed or abolished after vigorous struggles with the alumni. The fraternities and sororities reward those who seem to have a due regard for the amenities, who are pleasantly companionable, and who seem to promise additional strength to their organization by a successful career. When the tense rebelliousness of many students is considered, it seems that there should be a legitimate function for some such campus institutions dedicated to relaxation.

How much fraternities add to the sense of frustration among the non-members is hard to say, but there is a notable bitterness in many non-fraternity members who organize to fight race discrimination, economic injustice, and current political abuses. People at ease in Zion are always offensive to the prophets, and it may be that fraternities do not greatly change human traits. Very probably no one type of social organization can be best for every one, but the college has some obligation to see that its community rewards are not so organized

and administered that the struggle for prestige results in immature behavior and false values. Here the social psychologist may coöperate with the psychiatrist and the dean, in working for the mental health of the community.

It is in the area of punishment and discipline that the psychological point of view has most changed the authoritarian procedures of the dean. Even without a psychiatrist to advise him, the students, in their self-government and discipline committees, have let him know how impossible some older approaches have become. The dean is often puzzled by the sternness with which the administration and faculty are viewed as natural foes, and by the contrasting sympathy, understanding, and loving-kindness that the students shew for one another. In the case of antagonistic roommates, for example, students are very generally long-suffering and tolerant, and will endure extremes of mental cruelty before asking for a divorce. The pleasure of speculating upon how the roommate got that way often seems to outweigh the inconveniences of his behavior.

This general approach is carried over into nearly all cases of discipline. The question, "Why did he do it?" must receive exhaustive answers before any attention will be turned to what should be done. And in answering this first question, the students amaze the dean with the extent of their information, the fertility of their imagination, and the depths of their sympathy with their fellows in their struggle against an outrageous world. In general they agree with the popular journalist who regarded wholly with pity the basketball players recently convicted of throwing games, as the victims of a society that had made young men want money.

There is not space here to debate the issues between the authoritarian and the therapeutic approach. The practical situation that confronts the dean is that the disciplinary procedures have been so democratized that they must rest upon the approval and confidence of the student body. This means that all rules are subject to constant discussion and revision, and that there must be a flow of information to the disciplinary bodies to prevent the growth of a tradition of violation of rules, as apparently happened at West Point.

If this information is not to come from a resented "spy" system, it must come from a broadly based counseling pro-

cedure which commands general support because of its obvious benefits. These benefits must flow from understanding of the individual and his development, and from help that is given to the student through the processes of his own insight.

Thus we are back again to the psychiatrist. From him, directly and indirectly (including the coöperation of the medical services, clinical psychologists, social psychologists, and common-sense counselors), must come an increasing understanding of the bases of personality and human behavior throughout the whole college community. With such an ideal understanding, of course, there would be little need for discipline and punishment. But short of such perfection, there is a need for some rules and for some method of dealing with violators.

The dean will tend to moralistic judgments in the name of justice, and the psychiatrist will want to produce insight. The two views will be reflected and will temper each other in the disciplinary committees. In cases of cheating, for example, there will be general agreement that it should be eliminated as far as possible, and that some form of punishment should be given to the individual offender. But punishment will not be enough. The eradication of cheating is a complex community effort. Faculty members carry a heavy responsibility in their methods of teaching and examining. There should be a healthy pleasure in learning, some sense of achievement beyond rote memory in an examination, and a respect for teachers and classmates based upon a real acquaintance with them.

There will be similar agreement about the social undesirability of stealing, and a shocked feeling that any one in dear old Alma Mater should stoop so low. But stealing is a pretty constant offense on all economic, social, and intellectual levels of student life. Case studies of college thievery show the offenders to be motivated by an unbelievable complex of early maladjustments and to require a wide variety of treatments. Here the dean is often faced with a direct conflict between the individual and the community. It is usually best for the individual to remain a respected member of the group while attempts are made to give him insight, but the interests of the community may demand his prompt removal. Here,

again, punishment is not enough, and parents should be advised in detail about their responsibilities for some further treatment.

In cases of violation of rules about sex and alcohol, the situation is complicated by continuous disagreement over changing mores, and by the fact that the greatest distress to individuals may result from situations in which no rules have been violated. There is no rule against falling in love, or against drinking off campus, as long as it does not result in drunken behavior. A simple dean might enforce to the letter all the rules keeping men and women out of one another's rooms, or observing hours, or keeping alcohol off campus, and still have a student body deeply disturbed by sex and drink.

Here the dean's territory is like the one-tenth of the iceberg floating above water; the psychiatrist deals with the submerged nine-tenths. And he must deal with it largely in terms of professional confidence. Successful treatment demands that conduct that may violate rules and shock the dean and his public must be kept hidden while being analyzed without suggestion of moral disapproval. The contrast between this and the punishment given known offenders inevitably tends to make rules seem arbitrary and artificial, but certain rules of behavior must be agreed upon and enforced with some regularity if the college community is to have the approval of society in general.

Thus far, in the discussion of the processes of admitting the student, advising, rewarding, and punishing him, nothing has been said of the curriculum of studies, which is, after all, central in the purposes of the college. Viewing it here from the single aspect of its effect on the student's emotional life, it obviously may fill him with object interest, give him new enthusiasms, and spur his ambitions. In a somewhat negative way, it may at least, in the language of Cardinal Newman, "take the mind off itself, expand and elevate it in liberal contemplation, parry the assaults of moral evil, and keep at bay the enemies, not only of the individual soul, but of society at large."

So far as the curriculum is a frustrating experience for normally active and intelligent students, it is often so because it is in the hands of specialists who have little concern for the human aspects of education. Interest in the field is taken

for granted, and if it is not there, so much the worse for the student. The revolt against the curriculum of the nineteenth century was against the limitations of classical and ecclesiastical prescriptions. The revolt in the twentieth century has been against the dominance of specialists with little centrality of purpose and a consequent disregard for human interest. The specialists have been thorough and zealous, and have brought about an astonishing growth of knowledge, but they have left many students uninterested and suffering from a sense of the futility of all knowledge.

This revolt in the colleges against the specialists has taken four somewhat different forms, and the comment here is limited to the effect produced or sought in the emotional life of the student. A student-centered curriculum has been especially developed at Sarah Lawrence College. Here there are no uniform requirements. A student, with his faculty adviser, selects the courses that seem best suited to his interests and abilities. Further, each professor tries to adapt his material to his students and their purposes. His aim is not so much to lay the groundwork for future specialists as to speak always to their condition. He must, therefore, know them, and this is really possible only in the small college. The end sought is the alert, interested, creative individual who selects from the fields of knowledge what he desires to assimilate. If he differs sharply from his fellows, all the better. Individuals have been created who will solve their own problems in their own ways.

At the opposite extreme from this is the curriculum of the "model" university as developed at the University of Chicago. Here the revolt is not so much against the inhumanity of the specialist as it is against his insignificance. Centrality of purpose is to be restored at whatever human cost. The university, according to Mr. Hutchins, never asks what is good for individual students, but what is good for all students. Its curriculum is composed of the master works in the traditional fields of knowledge, and a student proceeds on his individual initiative to pass as many examinations as he can as rapidly as possible. His personal manners and morals and general stability may be left to the church and the home; his progress at the university is to be measured in intellectual terms. Students who have a thirst for the mastery of great

books and a reasonable respect for the wisdom of the past will find great emotional satisfactions in such a curriculum and will be sustained by it. Those who lack sufficient maturity to relate their own concerns and purposes to the books that are for all time will have to find their satisfactions elsewhere.

Two other types of curriculum lie between these two extremes. The third type pays little attention to fields of knowledge or to the traditions of their development, but asks what students need to know in order to fulfill their obligations as citizens—to care for their health and that of their families, to understand the problems upon which they are to vote and to speak and write persuasively upon them, to have at least a minimum knowledge of the physical world in which they live and a vocational skill for earning a living. This is sometimes called general education for participating in the democratic process, as opposed to the older and more aristocratic tradition of liberal education for leadership. All through the curriculum is a constant concern for the problems of daily living. This curriculum has been evolving chiefly in large universities with many students who do not care to follow abstract studies. For the general run of these students, such a curriculum will provide real significance and satisfaction, to say nothing of the public benefits.

A fourth approach emphasizes the unity of the learned community. Its courses are largely prescribed in order to assure the ability of scholars to talk together with the understanding that comes from a common background. The principal areas of traditional and contemporary learning are selected, and no student may completely ignore any of them, even if interest has to be compelled and discipline invoked. His own interests will probably be the basis for future specialization, but in the early years, at least, he is to acquaint himself with disciplines that may never interest him. The college in this case may accept a substantial responsibility for the adjustment of the individual and may attempt to achieve it by a large measure of self-government in the community life, by a somewhat supervised extracurricular program, and by an active group of counselors.

Each of these curricula has been developed by an eager

group of educational reformers in the hope that it will absorb the energies of students and produce well-educated men and women. Each curriculum has remedied glaring faults in preceding educational methods, and has usually produced new ones. Students are being both excellently and badly educated in all of them. A large number of the students can adjust themselves to the curriculum and social institutions of almost any college. If they have strongly marked preferences, they can select the school that, upon investigation, seems most likely to be a spiritual home.

Neither the dean nor the psychiatrist will want to remake the college for its misfits, or to hold the curriculum too strictly accountable for student faults in temperament and personality that have been developed in the pre-college years. Their most useful service will be to increase human understanding and insight among faculty and students, whatever curriculum may be adopted.

Two lines of approach seem most promising. The first is the development of an adequate counseling system. Only trained counselors will be likely to understand the dependence-interdependence struggles of adolescents, and the necessity for varied approaches according to temperament and personality. In smaller institutions at least, faculty members should have a large place in the counseling, chiefly because of the added understanding it will give them of their students in class and out. But it cannot be taken casually, or imposed as an added burden. Probably one or two clinical psychologists should be in the group. Considerable prejudice and misunderstanding will be encountered, but by meetings and discussions of cases this may be overcome. If a group of faculty counselors could be brought to understand the problems of their students, and to follow them sympathetically, it would affect the whole spirit of learning in the college, to say nothing of the benefits in particular cases.

Student counselors in various capacities, hall presidents, proctors, and members of various committees will have less initial prejudice and inertia to overcome. They may suffer from an excess of zeal, but they have qualities that more than atone for these faults, and through their training for their work, will greatly increase human understanding.

Enough case histories are now available from the publications of college counselors to result in some generalizations that should be of central importance in the daily living of students. Such generalizations, supplemented by discussions of case histories, by established knowledge of the bases of human nature, held in focus by questions arising from the habits and attitudes of the particular college class or group, might well form the basis of a course that should be in the curriculum, but that should have certain distinctive qualities. It should not be purely academic; it should be freed from too much formally prescribed content; it should not place great emphasis on the final examination or grade; it should carry college credit toward graduation if not toward a major; and it might well be included in the department of psychology or biology.

If such a course aims consciously at illumination rather than formalized knowledge, it is certain to be suspect, but what courses now established have not endured their period of suspicion? A beginning in this direction has been made at Swarthmore. The psychiatric consultants, Dr. Leon Saul and Dr. John Lyons, have for two years conducted a one-hour non-credit course of lecture discussions. They have been learning from the students what seem to be their central problems. To these problems the psychiatrists have brought the insight of their professional training. They have given the students a greater understanding of themselves, to say nothing of the education they have given the dean. But the time limits of a crowded curriculum make it impossible to do justice to work of such importance in such a casual fashion. It should have the time of a regular course, supplemented by individual conferences. Its aim should be generally educational and, to such an extent as possible, therapeutic as well. It should be available to all students who are interested.

The coöperation of the dean and the psychiatrist, however, will not find its chief significance in the addition of a new course to the curriculum, important as that may be. It will rather be in the attempt in all possible ways to see that the activities of the college, in the curriculum and out, are based upon an understanding of the complexities of the individual and his relation to the community.

THE PSYCHIATRIST AND THE DEAN—PAST,
PRESENT, AND FUTURE

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I APPROACH this problem from two points of view—first as an administrator, formerly at the secondary-school level and recently at the college level, where I found that taking care of students included learning how to work with psychiatrists; and secondly as an educator who is much concerned with the times in which we live, the difficulties young people face, and the attainment of some understanding of how psychiatry fits into the attempted solution of the age-old educational problems.

It was not so many years ago that most men and women in education had never heard of a psychiatrist. Those were the days when the *raison d'être* of a college education was fairly clear in the mind of parent, professor, and student; when teachers were broadly trained, and transmitted to their students, in answer to a natural sense of responsibility as teachers, not only subject matter, but somehow a sense of understanding of the universe and man's place in the universe. Dr. Peabody, of Groton, used to say that education was responsible for the physical, intellectual, and spiritual development of students. You will note that he did not refer to the emotions, but somehow there was not as great need in those days to separate out the new component of "emotion"; an integrated approach to education gave the student an adequate integration within himself as he went through the developing years of college. And so in those days, Dean Briggs, broad of background, lover of men, clear in his concept of moral standards, and possessed of great common sense and understanding, did for his boys at Harvard what the general practitioner in medicine was doing for his patients.

With the advent of the scientific age, a plethora of new subjects in the curriculum, a vast increase in the occupations to which a college degree was an essential pass key, with greatly increased numbers of students, and with all the other bigs—big cities, big business, and big government, wherein the individual as an individual became lost in a card file—

students in college began to experience great unrest, along with their elders in the adult world. Teachers had become specialists, and despite the possible inclinations of the individual professor, the system had impelled him to transmit to his students a feeling that his was only an intellectual responsibility to the student.

And now, alas, the conscientious successors to Dean Briggs and his generation began to have new problems on their hands, to seek outside the university for some straw that would enable them to save their students whom they loved and believed in as much as Dean Briggs ever loved and believed in his boys. And so the new dear found the psychiatrist, the clinical psychologist with his aptitude and projective tests, and the reading specialist. By spending frantic hours with students, their parents, and these outside agencies, our new dean found that he could "save" many of his boys. As he tried to do his full duty, he attempted to transmit to his students a sense of wholeness, unity, and integration.

And so he began to talk to his colleagues on the faculty about bringing these specialists to the campus. Gradually, despite the feelings of the faculty member that here was some one usurping part of his job, here was some one penetrating the privacy of individual students beyond the right of the educator so to do, these agencies moved to the campus, although clearly located on the fringe of the main stream of activity. Only a very few institutions have begun to learn how truly to integrate these new insights and disciplines into the main stream of the college program, but real progress is being made in some places.

At this point, may I narrow the scope of my remarks to a discussion of the relationship of the psychiatrist and the dean at Massachusetts Institute of Technology, as my concept of a program that is at the present time as near the frontier of progress as any comparable situation in the country with which I am familiar. Please don't misunderstand me—neither Dr. Farnsworth nor I believe that it is perfect, and at the close of these remarks I should like to make a few observations on what I think future action should be, but we both believe that we have to-day a very satisfactory working relationship. Let me discuss briefly the present situation.

First of all, let me apologize for appearing to assign certain

characteristics or virtues to myself. In describing the dean in this situation, I merely outline what my ideals and objectives are, whether or not I am successful in living up to them.

What, then, must be the attitudes and characteristics of a dean-working parallel, in terms of organization, to the psychiatrist? (Both Dr. Farnsworth and I are directly responsible to the president.)

First, the dean believes implicitly that education demands the integrated development of the student physically, intellectually, emotionally, spiritually, and socially, and that, therefore, the faculty being responsible for the educational program, the faculty must take responsibility for the impact of the institution on the student in all these areas. Second, he believes that students must necessarily be products of their environment and, consequently, that their further development demands a knowledge and understanding of that environment. Third, he believes that the foundations of democracy and the Judæo-Christian tradition lie in the uniqueness and sacredness of each individual as a son of God, and that, therefore, education must revolve around concern for each individual as a whole person. Fourth, the dean must believe implicitly in the basic *desire* of each individual to do what is right, regardless of what he may have done or be doing. Fifth, he must believe in his students and transmit to them a feeling of trust and love. Sixth, he must have a clear sense of moral standards, values, and ideals which grow out of the ideals of the institution and the state and country in which it exists.

With these six basic beliefs, what, then, must be the dean's attitude toward the psychiatrist and psychiatry? First, because he believes man is of emotional parts, he understands that emotional disturbance can acutely influence or clearly explain a student's actions and attitudes. Therefore, he cannot, to quote Dr. Farnsworth, "look upon every variant from accepted social behavior as a challenge to his authority."

Second, he understands that emotional disturbance and consequent antisocial attitudes and actions very often arise out of inadequate satisfactions in the present environment, regardless of the influences of the past environment. In handling any situation, therefore, he is sufficiently permissive to weigh the aberration of the student against the faults of the environment that may well be causing even wider aber-

rations from the norm than the dean knows. (And the psychiatrists almost invariably know of any such widespread aberrations.) For the same reason, the dean is not tempted so easily to start on a witch hunt, but rather, perhaps, to start working, with the help of the psychiatrist, on the faculty committee on student environment.

Third, he assumes that the good modern psychiatrist is, of course, completely permissive in his relations with individual students, but handles the student, and, therefore, his recommendations to the dean, on the basis that there are standards, and that somehow the individual must face up to and conquer his problems within at least an outward acceptance of the standards of the community.

Fourth, the dean must be so oriented to the facts of life, and to the psychiatrist's interpretation of these facts, that he is no more easily shocked by them than the psychiatrist himself.

Fifth, the dean must have a relationship with the psychiatrist of such mutual confidence that he can be given rather full, confidential information about a student and then, in fairness to student, family, psychiatrist, and institution, handle a given situation without revealing special knowledge.

What are the particular strengths in this situation? Because we can work very closely together and yet are parallel in responsibility, we can serve as a check on each other in relation to the welfare of the student or the institution. As the dean must be responsible both to the rules and regulations of the school and to the parents—or, to put it another way, as the dean can approach the individual student and the family as a layman interested in the whole man—he can often help the family or the student to interpret the recommendation of the psychiatrist in relation to test scores, the opinion of the family, the faculty, the fraternity, student government, or the family doctor.

Are there any weaknesses in this very modern set-up and have we yet found the proper rôle for psychiatry in education? I believe Dr. Farnsworth and I both agree that there are weaknesses and that we can still improve the rôle of psychiatry in education.

The weaknesses in the present situation, as I see them, are primarily three in number. First, psychiatry and psychiatric

insights being almost entirely connected with the medical department, the psychiatrist becomes bogged down in taking care of individual patients—many of them our weakest citizens in relation to their present ability to profit from our program—and is, therefore, handicapped in being able to contribute his insights to the main stream of the educational process. Second, because of the great student demand for psychiatric assistance, the department has become very large, with the consequent feeling arising too often in faculty and administrative minds—and perhaps with some justification, I might add—that psychiatry is too much in the saddle. Third, in relation to the friendly running argument that Dr. Farnsworth and I are constantly indulging in—namely, the permissiveness of the psychiatrist and the moral standards of society—the psychiatric insight being only in the medical department, where patient-doctor professional confidence exists, too often a bad moral situation, either for the individual or for the community, is allowed to drag on interminably, contributing both to the detriment of the community and to the inefficiency of the psychiatrist in helping his patient to face reality.

What, then, is the direction of the next step? I think the answer lies in the importance of faculties' once more facing up to the fact that education is the development of the whole man and that, therefore, their responsibilities, both as teachers and as deliberative bodies forming educational policies, are toward the individual student, recognized as unique and sacred as a son of God, and possessed of physical, intellectual, emotional, spiritual, and social parts.

I, therefore, visualize that the next step lies in having the man trained in medicine and psychiatry step out of his rôle as private physician and join hands with the philosopher and the clergyman, who would likewise step out of their rôles as professor of philosophy and minister—all three forming a team that would work intimately with the scientists and social scientists to find the intellectual answer to the integrated education of an integrated individual, who may be following any one of a hundred or more specialized interests in preparation for his career, but who must also be prepared for self-fulfillment and a rôle as contributing citizen to his society.

Because of the size of our institutions and because of the

many fields of knowledge now being studied, realistic student-counseling systems must be set up. It is in this area that I see the psychiatrist, fortified with insights from his teammates in philosophy and religion, playing a vital rôle in education in the next few years. And as this is done, and done successfully, our medical departments can be reduced in size, and psychiatric attention for the individual assume a place comparable to medical attention for the individual.

PSYCHIATRY'S AID TO COLLEGE ADMINISTRATION

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THE association of psychiatrists with college programs is now in many places past the experimental stage.

This event is the result of separate developments in the fields of college education and of psychiatry. Developments in education are well known; there is growing recognition of the necessity of educating the whole person if he is to function in a truly enlightened manner, and of utilizing the discoveries, by educators, sociologists, and psychologists, of the relation between what may be called emotional adjustment and the ability to learn.

Changes in psychiatry have served to interest psychiatrists in education and to increase their usefulness to it. As a medical specialty, psychiatry for many decades interested itself mainly in classifying diseases of the mind and doing little else except applying such remedies as came to hand. In the last half-century, with the scientific study of concepts of emotional growth, maturity, and unconscious motivation, a new cause-seeking and dynamically oriented discipline has arisen. Not only has this increased the possibility of the treatment and cure of emotional disorders, but it has brought new understanding to a whole range of normal processes, such as adolescence and learning. Thus it is that the psychiatrist begins to be able to be of some usefulness in the scheme of education.

This discussion describes how the psychiatrist works in re-

lation to one important member of the educational team, the dean of students. Experience at the University of Chicago will form the basis for the discussion and only areas of co-operative function that were worked out there will be described. Still other areas of fruitful interaction have been explored at other institutions and further development is surely probable, but the activities discussed here are undoubtedly basic elements in any well-founded program. It can be anticipated that, as these areas are mastered, psychiatry will contribute increasingly to the practical jobs of college administration as well as to methods and philosophies of higher education.

The purely medical and treatment functions of the college psychiatrist might seem at first glance to have little meaning for the dean. In fact, the treatment of students is an area that requires such great respect of confidences that individual cases are not discussed with him. The dean is, however, properly concerned with problems of student failure, social adjustment, and standards of health. In college health programs, dealing for the most part with relatively young and vigorous people, emphasis falls on the prevention of disease. In the college psychiatric program, preventive measures are threefold: first, in the selection of students; second, in case-finding efforts to achieve early detection and treatment of emotional disturbances; and third, in general measures designed to aid the college in the development of a healthy emotional environment for its students.

In the psychiatric clinic, prevention of failure in emotional adjustment, often with consequent academic and social failure, is sought through prompt availability of consultation and, if the problem is amenable to briefer methods, treatment. Case-finders are numerous. The dean and his staff, advisers, professors, and dormitory officials, but above all the students themselves, are quick to sense a disordered integration and bring the attention of the student to his need for help. Easy access to psychiatric attention might seem to bring the risk of overemphasis and abuse; yet over a period of four years, less than 2 per cent of such referred cases have been found to be without adequate basis.

It is difficult to estimate how much is accomplished by treatment in preventing students from failing or becoming dis-

ciplinary problems or worse, and thus being of immediate concern to the dean of students. Suffice it to say that the gratification of such work is great to the psychiatrist in the reward of seeing students become better able to realize their potentialities.

Emotionally upset people may be expected to become conspicuous problems to the dean. The ability of the psychiatrist to make judgments about such problems, and even to remove disturbed students from the college community by hospitalizing them if they are dangerously ill, or recommending a leave of absence for medical reasons, may protect them from getting into more serious difficulties. Such action is taken solely on the basis of the student's welfare, never for the convenience of the administration, although frequently the two coincide. For example, it is usually not wise for a student to be permitted to avoid his usual academic or social responsibilities, unless for very short periods, and it may be embarrassing to the administration for this to occur. If he cannot carry on his college responsibilities adequately while under treatment, the student may be advised to leave college until he can do so, with appropriate treatment while away. It may be affirmed that this is often extremely constructive action; a majority of those so advised return later with greater maturity and succeed as never before.

The function of evaluating the emotional capabilities of students for work and life in college has been extended to the selection of students. This work with the office of admissions was stimulated by the observation that the usual criteria for admission failed to screen out a number of students who fairly soon demonstrated their unfitness for what they were doing. They not only presented problems to the university, but found themselves dissatisfied.

A workable program of consultation between admitting officers and the college psychiatrist brings new light to selection procedures. It is feasible for the psychiatrist to interview applicants who fulfill ordinary criteria, but who raise misgivings in the minds of the admitting officers. These officers can be encouraged to test their intuitive misgivings by sending such applicants to the psychiatrist with a forthright explanation of the reason for referring them.

The results of such examinations have been interesting.

Several applicants were found who could not possibly have got along in college because of serious disturbances and who could be redirected to treatment or to healthier occupations. Others, not actually ill, have presented obviously inappropriate motives for seeking admission—for example, to escape from daily family conflicts with which they have been unable to deal, or to satisfy the demands of ambitious parents. Such motives do not make for success in students; in fact, they may constitute powerful blocks to success and may even lead the student to acts that are not constructive. Quite a number of applicants in this group can achieve some understanding of their problems in a single interview and may decide on more constructive solutions to immediate problems, later approaching college with more maturity. Equally interesting are the students who have had uneven or scholastically poor careers in the past, but who have overcome the basis for their difficulties and are ready to approach college work with more realistic attitudes. Some of this latter group, who might not originally have been considered suitable candidates, have later made brilliant records.

The psychiatrist's purpose in evaluating applicants for college is twofold: first, to protect the student from undertaking tasks for which he is not prepared or to help him become able to deal with them; and second, to save the college from investing time and energy in persons who cannot make successful or profitable use of its facilities.

Students who are referred by the dean or his staff for evaluation for admission or in regard to disciplinary action are always informed that the psychiatrist will make his opinions known to the dean. This permits the psychiatrist to discuss some of the problems involved, to the mutual advantage of all concerned. The admission officers have been able to sharpen their abilities in selection; the psychiatrist has been educated in problems of administration and led to broader perspectives.

Another function of the psychiatrist is the evaluation of disciplinary problems that arise among students. Such evaluation is made before the disciplinary committee makes its final decisions on a case, so that the psychiatrist's understanding and recommendations can be considered. Disciplinary action can be looked upon as an attempt to solve problems, rather

than as a purely punitive measure. Some students who present such problems have been found to be grossly disturbed, and in these instances the problem becomes a medical one and appropriate steps are taken.

In most cases the psychiatrist is able to learn something of the motives for behavior leading to the possibility of discipline and can suggest action that will tend to relieve the problem. Such recommendations are sometimes in the direction of more strict action than the behavior itself might indicate. For example, a young student may be caught stealing books from a need to call attention to his anxiety about being free from the close control his parents had exercised. Failure to give him the security of positive disciplinary action would lead to greater anxiety and more blatant asocial activity.

The dean should perform this function so that students do not generally regard the psychiatrist as an officer of the administration, which would certainly destroy his usefulness. Rather, they tend to look upon the psychiatrist as the interpreter of their needs to the administration. In all these situations the opportunity for communication between the dean and the psychiatrist helps in the mutual understanding of the needs of students and ways of meeting them.

Whether or not the dormitory system is under the jurisdiction of the dean, the living situations of students are certainly of concern to him. Dormitory life brings with it many special problems in personal relations, some of which are difficult to solve by administrative action alone. The psychiatrist should be available to the dormitory officials in regard to these. Here, in addition to helping work out problems as they arise, is an opportunity to engage in preventive activities. In conferences and group discussions with student dormitory leaders, the usual problems encountered in dormitory life can be delineated, together with practical ways of dealing with them. More important is the work of demonstrating to these leaders their responsibilities toward their students, of showing them that only by exemplifying responsible attitudes in their jobs can they cultivate individual self-responsibility in the young people around them. It is remarkable how easy it is, in this era of demands for freedoms,

group dynamic lines with the aim of diminishing anxiety rising from this area and emphasizing the desirability and importance of taking individual responsibility for conduct. That there is need for such discussion may seem surprising, as it is easy to assume that college-age students have settled on satisfactory solutions to their sexuality. However, we have learned that many are not yet ready to meet the actual situation of dormitory pressures, freedom from parental supervision, or other factors, in spite of much theoretical knowledge. Students of all ages are generally grateful for such sessions. The psychiatrist usually finds it inadvisable or unwise to engage in extensive educational activities, health courses, and so on, although in some colleges such programs seem to have contributed a great deal.

The purpose of this enumeration of some of the activities in which psychiatrists engage in close concert with the dean of students has been to illustrate the grounds for collaboration and something of the psychiatrist's contributions. In order that such a collaboration can be most effective, it is necessary that the psychiatrist and the administration have mutual confidence and respect for each other. A brief description of some of the desired elements in such a relationship will further clarify the rôle of the college psychiatrist.

The first requisite for a successful collaboration lies in a clear understanding and definition of responsibilities. The boundaries are actually well defined by the respective disciplines of psychiatry, a medical specialty, and academic administration, a discipline combined from education and the various business skills needed in the management of groups of people. It should be clear at once that there is no conflict of working area between these, so that no confusion of responsibility need occur. In any case, the dean never attempts to practice medicine or to tell physicians how to do so, nor should medical-psychiatric recommendations or opinions be open to question so far as the patient is concerned. On occasion, the rationale of certain recommendations can be discussed without violating any professional confidence. The psychiatric staff, on the other hand, should have no need for administrative authority or any reason to question administrative decisions other than in broad, general ways. Administrators and psychiatrists generally agree on the need

for the price of freedom to be forgotten. That price is responsibility.

Young house heads are often inclined to feel that far-reaching permissiveness is the attitude to take toward their charges, forgetting that most college freshmen are not quite prepared to deal with such permissiveness and may even become upset by it, manifesting their anxiety in a variety of ways, few of them conducive to a good adjustment. When the leader can be shown that it is his responsibility to set some limits to freedom in the dormitory, and that by taking this responsibility he both gains the students' respect and makes them more comfortable, he becomes much more effective.

It might be said that the need to learn to take personal responsibilities of this kind seems to be a general one in this society. It is only when this has been learned that education for responsible living can be effective. This is not, of course, a viewpoint championed only by psychiatrists, but an approach that many educators have adopted. Pitfalls that endanger a healthy attitude toward responsibility lie on both sides—on the one hand, the idea of unlimited permission and on the other a too repressive and restrictive approach. Examples of both extremes and their results are plentifully evident.

Functions similar to those that have been described in relation to admission officers and dormitory officials have been carried out in other special situations—with advisers, with the medical personnel of the student-health service, and with administrative groups of various graduate divisions and schools of the university. The psychiatrist's aim is always to understand as clearly as possible the reacting forces in each situation and to aid all individuals in the institution to the attainment of an appreciation of the emotional factors of interpersonal relationships. Since one of the psychiatrist's tasks is to interpret the emotional needs of students to the dean and his personnel, he must always stay close to the job of treatment to remain effective in this.

It is the intention of the modern college to educate students to be ready to assume responsibility in wider areas of life. Hence, the psychiatric staff has taken some share in educative activities. Discussions of sexual adjustment in college have been useful. These have been conducted along

to require social and academic responsibility from students if they are to have the privilege of college training.

There are times when the psychiatrist becomes aware of an administrative policy that he thinks is psychologically unsound, and he would be remiss in his duties if he did not make his views known. For example, the wisdom of segregating young entering students in the dormitory system might be discussed in terms of the emotional significance of such action. Similarly, the dean has no hesitancy at all in telling the medical staff when he thinks they might be straining the limits of medical responsibility in their activities. Obviously this requires respect for each other's professional abilities; should there be doubt on this score, working together would be impossible. It is clearly necessary that the business relationship remain a professional one, between specialists in their separate fields. This makes for a certain degree of formality in consultations, which of course, need not interfere with friendship.

Finally these mutual efforts depend on an attitude that must be shared, compounded of a wish to learn, willingness to change or even experiment, and a tolerance for some degree of fallibility.

POTENTIAL PROBLEM AREAS OF MUTUAL INTEREST TO THE DEAN AND THE PSYCHIATRIST

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ONE of the most delicate problems that surrounds the proper function of a physician, and particularly a psychiatrist, in a college setting is that of preserving the confidential nature of the physician-patient relationship. As all of you are well aware, anything that the patient divulges during the course of a medical interview may not be used by the physician without the patient's permission, unless the welfare of others is directly at stake, as would be the case if the patient had a communicable disease. In the psychiatric field, there are certain close parallels, such as the presence

in the patient of definite overt suicidal or homicidal tendencies. Leaving these extremes out of consideration, the patient should feel free to communicate his true ideas and feelings to the psychiatrist without fear that they will be related to others and used against him in any way. Let there be a violation of confidence on a college campus, and immediately the news spreads, and the usefulness of the psychiatrist is virtually at an end.

From the standpoint of the referring faculty member or dean, the problem is not so clear-cut as that. He feels a certain responsibility to the student, his family, and the college. He would like to know what was found, whether he can help further, what his attitude is to be in future conferences with the student, and what can be done to help other students who may have similar problems. If he calls the psychiatrist, asks about the student, and is told that the confidential physician-patient relationship prevents the divulging of anything about the problem, he is not going to feel very happy about the situation. On the other hand, if the psychiatrist does give a general outline of his findings, and the faculty member tells this to the patient, the psychiatrist will properly be blamed. The middle ground that is possibly most satisfactory is that in which the psychiatrist discusses general problems faced by students without bringing in private personal material. In this way the faculty member gains some insight into the nature of the problem without having details given him. But even that much information he must handle discreetly.

The sharing of information with the parents of a patient is a somewhat different problem. If parents ask for an interview, they obviously must be granted it. If the patient knows that they are coming, his permission should be obtained if any information is to be divulged. If permission is not granted, then the psychiatrist gets all the information from the parents he can obtain, pointing out that it is for the good of the patient. At the same time he resists demands for information for the obvious reason that to do so would tend to destroy the treatment relationship. If the student is incapable of using good judgment, the parents are, of course, then given whatever information is necessary to enable them to make wise and appropriate decisions.

Another type of complication is the situation that arises when a student, in the course of an interview, discloses that he is violating some of the basic rules or customs of the dormitory in which he lives. If the psychiatrist reports such a violation to the dean's office, he will get no similar information in the future either from this student or from others who hear about the episode. If, on the contrary, he does nothing about it at all, he may be accused of not trying to support the standards of the college. The average psychiatrist would, I believe, not report such episodes to any administrative office, but would try to help the student understand that such deviant behavior will work to his disadvantage in the long run. He could, after the lapse of suitable time, indicate the general nature of the problem, so that student-government officials and others concerned could try to prevent future violations.

As a general rule, a psychiatrist does not find one violation without finding others, and he can then discuss the whole problem without harming any one individual. Not long ago one of the members of our staff was consulted by a student who had got himself into trouble with the legal authorities, and the episode might possibly affect his relationship with the college itself. He was told by the psychiatrist that he should by all means notify the proper college officials of his predicament, and that this would probably make it easier for him than if he tried to cover up his acts still further. The manner of divulging this information was left up to him. Unfortunately he did not choose to do this before the information became available to the college officials from other sources.

Although undue publicity in this matter may be misunderstood, it is usually advisable for the psychiatrist and the dean to have a close working relationship, so that the dean can be aware of the psychiatrist's problems and similarly the psychiatrist can understand the dean's viewpoint. If the dean does not take a punitive attitude toward students, but instead tries to get at the meaning of their behavior, the psychiatrist can be of very great help to him. If the dean looks upon every variant from accepted social behavior as a challenge to his authority, then communication between the two offices must of necessity be very scanty.

The college psychiatrist usually prefers to see no one for in-

dividual conferences unless that person wants, or is at least willing, to see him. The methods of furthering this desire or willingness to seek help should never include misrepresentation of the psychiatrist's status, though occasionally a student may be reassured by the knowledge that the fact that he is to see a psychiatrist does not mean that he is "crazy" or that his future is jeopardized by publicity of his going. Of course, in some cases involving discipline, and in those where possible psychotic action is involved, such desire or willingness may not be possible.

One of the difficult problems that any psychiatrist faces in working in a college setting is that of preventing himself from being overwhelmed by the demands for conferences with individual students. If a psychiatrist does succumb to this pressure, he limits his usefulness quite sharply, and becomes merely a technical aid for disturbed students, and is of little value in preventing emotional disturbance. The best ratio of time spent with students and with faculty and administrative members is yet to be determined, but in my opinion is about fifty-fifty. The more a psychiatrist can help the individual faculty member with his counseling problems, the better off the entire institution will be. Every time a professor or the dean works through a delicate situation with some professional help in the background, the more capable he is of solving the next situation effectively.

The psychiatrist's main responsibility to the college is to awaken an awareness or a sensitivity to this great range of personal problems. It is not his purpose to develop amateur psychologists out of the teachers. His job is to help them to become better teachers. To be good teachers, they should be good counselors. Every contact with the student is in reality a counseling situation. The development of an adequate counseling program might well be the joint responsibility of deans and psychiatrists, together with other related disciplines.

Some teachers are very suspicious of acquiring any of the newer techniques of counseling because they fear that there is some kind of regimentation back of the whole idea. They may say that pediatricians and child psychiatrists have developed new techniques only to drop them when still newer ideas come along, and they do not want to become "dated"

similarly by acquiring confining techniques. Counseling is a process, a point of view, a way of approaching all sorts of new and unfamiliar situations, a set of attitudes, and not a fixed technique.

The type of counseling I am talking about is designed to free the individual from his internal conflicts instead of regimenting him in any way. The counselor in this sense should be a good listener. He makes no moral judgments on the material that is given him. He knows that for many problems there is no answer, but that the mere formulation of a problem will objectify it enough for the student to make either a constructive attack on it or a sensible defense against it. Many counselors think that their function is to give the student advice. This is rarely necessary or appropriate. The student needs to develop independence and confidence in himself. He may request the teacher's frank opinion on a given question and get it, but he weighs this against the contrasting opinions of other teachers and then makes his own choice.

It is easy to give lip service to this concept of counseling, but very difficult to get it across in a college setting. Some teachers make easy and stimulating contacts with students without any training. Others are very insensitive to the subtle reactions of their students. There is much that can be learned, however, if a desire can be inculcated in the members of the faculty to learn more about this field and if they have a chance to work out their feelings in small groups. Sometimes such small groups or seminars can be based largely on the methods of handling typical classroom situations. In other groups a deeper level of understanding is sought for, and the members who participate in it study their own emotional reactions in the group setting, criticize each other vigorously, but kindly, and when they understand their own reactions, are in a position to appreciate the reactions of their students.

A most delicate question that arises from time to time in all schools is what to do about the social deviant, the person whose heterosexual development is not complete. I find it advisable to treat such an individual in exactly the same way as the so-called normal person. If he violates the privacy of some one else, then he must take the consequences just as does the

student who offends a member of the opposite sex. Any student who asks for psychiatric help should receive it on a private, confidential basis. Such cases can be, and frequently are, helped.

This attitude does not increase the frequency of socially unacceptable behavior. The advantages of normal behavior are too great for that. Some schools have a reputation for getting rid of students of whose behavior they do not approve and then pride themselves on having solved the problem. I have not seen any school yet that has solved its problems successfully in this way. Treating such persons as patients, which they really are, does offer hope of satisfactory rehabilitation.

In our relationships with the faculty, we try to stress the important point that the psychiatric service does not want any special favors granted to students with emotional problems that would not be granted under similar circumstances to students who have physical ailments. This principle is somewhat difficult in its administration. It is quite obvious that a student with a broken leg may have to be out of class for a week or even a month. It is frequently not so obvious why a student with an emotional problem should be permitted to miss classes.

The chief reason why we do not want a student to get any secondary gains from his illness is that it is not good for him, in that it does not mobilize his own efforts toward recovery. It often happens that a student sees the obvious advantages in having one or two courses dropped from his schedule, and then he conceives the idea that it would be nice if his four years of work could be spread out over five or more years. This we never recommend from the psychiatric point of view. If some alteration is recommended for the student's schedule, it is strictly understood that it shall be for one semester and shall not be a permanent thing. To make a permanent alteration would be to cheapen the degree that the institution confers.

A difficult situation sometimes arises when, in the opinion of the psychiatrist, the student is too ill to remain in school and yet neither the student nor his family are convinced of this fact. In such a situation we make a recommendation to the dean that the student be given a medical leave of absence

and that his return be conditioned upon a satisfactory report from his psychiatrist or from our own medical department or both. It then becomes an administrative problem as to whether the dean wants to give him this leave of absence whether he wishes it or not. We prefer that psychiatrists have no power to enforce any of their recommendations. On the other hand, we do have the feeling that if our recommendations are not followed and the reasons for not so doing are not satisfactory, it is probably time to get a new psychiatrist. This may seem like "a distinction without a difference," but I think it is a very vital one. The physician or psychiatrist should not be put into the position of usurping the power of the regular administrative officers of the college. He should be kept as a consultant. His ultimate value to the administration will be much greater if this distinction is clearly understood both by the administration and by the student body.

Occasionally a complication arises when a student is requested to take a leave of absence and pressure is applied to have him continue in school. Once when we made this recommendation to a student, he objected very strenuously over a period of a few hours and was strongly seconded by his father and the rest of his family. As a final gesture, he said that if we did not change our minds and let him remain in school, he would commit suicide. I informed him that if he did so, it would merely prove the wisdom of our decisions, and as it turned out, he did not. Direct and indirect threats of suicide are not infrequently used by a certain type of patient in order that he may gain his end, but both deans and psychiatrists must have the courage not to let this threat cause them to make decisions that are not in the best interest of the patient and his family in the long run. The dangerously suicidal patient can usually be differentiated from the above type.

Occasionally a student may request a leave of absence a week or two before the end of a semester, and his reasons may seem entirely adequate to the psychiatrist. After it is granted the student then may have a change of heart and decide that he wants to come back to the college the following semester. This we never agree to unless the circumstances are quite unusual and are thoroughly understood by all those concerned. We indicate to such a student that if his emotional disturbance

is of such a nature that he should be allowed to have his registration canceled, then it is very unlikely that any major recovery can be made without treatment or without some life experience that will help him resolve his problem. Mere statement of intent on the part of the patient is not enough. The problems involving leave of absence are particularly acute now that there is a national crisis and the question of military service is always in the minds of students.

Near the end of every semester, there are always a few students who want special favors and who think that by making out a case for an emotional disturbance of several weeks' standing they can be excused for a poor showing in one or more classes. In almost all instances we point out to the student that such a procedure is unwise and that he must be held responsible for all his work. If this policy is consistently held, such requests are apt to remain few in number. Furthermore, care in these matters tends to maintain confidence in the judgment of the medical staff on the part of faculty and administrative staff members.

Dean Bowditch and I have talked a great deal in recent months about the question of the general attitude of the institution toward variations from what is considered to be the usual expected behavior. For lack of a better term, we have used the phrase "permissive attitude" to describe a point of view that we think is healthy in a college. This is not what it might seem to imply—namely, that anything goes—but rather that the level of tolerance of the college community is quite high for all kinds of variation from what is usually expected. The variation may take the form of some kind of emotional disturbance, an acting out of a personal problem in terms of behavior, some degree of character disorder, eccentricity in dress or manners, or variations in belief or ideology.

Adopting a permissive attitude does not mean that the institution does not have definite and high standards. It does mean that standards are treated as ideals, with slow, steady pressure directed toward their maintenance. It means that the individual is given prime consideration. If the standards are interpreted and enforced with rigidity, this tends to produce hostility on the part of the students involved. If, on the other hand, the standards are expressed in definite terms,

but with great understanding of the personal predicament or past history of the student concerned, then the deviant behavior will tend gradually to come back to an acceptable level and the student will have to solve his conflict in terms of the demands within himself instead of being able to project them out to the environment, thus blaming some one else for his shortcomings. We feel that a genuine permissive attitude on the part of a great majority of the college members is really a source of strength rather than of weakness.

Mark Hopkins expressed some aspects of this problem in his inaugural address at Williams College in 1836:

"The last objection against colleges which I shall notice, comes from another quarter, and is, that they do not teach manners. And it must be confessed that this is not one of those things for which we give a diploma. Good manners certainly ought to exist, and to be acquired in colleges, and more ought to be done on this point than is done. Still there are difficulties in the way which will be appreciated by every sensible man. In the first place, manners can not be taught by direct inculcation; they must mainly depend on parents and on associates during the earlier years of life. Again, many of those who come to college are of such an age that it would be impossible to remodel their manners entirely under the most favorable circumstances. They seem to have lost the power, which indeed some never had, of perceiving the difference between the easy intercourse of good fellowship which is consistent with self-respect and respect towards others, and a coarse familiarity which is consistent with neither. There is further apt to be a sentiment prevalent among young men, than which no mistake could be greater, that manners are of little importance, and that to be slovenly and slouching, and perhaps well nigh disrespectful, is a mark of independence. After all, college is not, in some respects, a bad place to wear off rusticity and break down timidity. And if those who make the complaint could see the transformation and improvement which really takes place in many, I may say in most, instances in a college course, they would perhaps wonder that so much is accomplished, rather than complain that there is so little. Still, when a young man comes with a frame of granite rough from the mountains, or as rough as he came from them, and has seen perhaps nothing of polite society, and, knows nothing of polite literature, it cannot be expected that he should learn during his college course the manners of the drawing-room, or the arbitrary forms of fashionable etiquette. If he shall possess, as perhaps such men oftenest do, that higher form of politeness which consists in respecting the feelings of others and consulting their happiness, and we can send him into the world with a sound head and a warm heart to labor for the good of the world, we shall be satisfied, and the world ought to be thankful. Such men often become the pillars of society."

The attitude toward the psychiatrist differs greatly on different college campuses. Many of us find that our services are not only welcomed, but are considered almost indis-

pensable. I am told that on some college campuses, however, the psychiatrist is looked upon with something less than enthusiasm, and that his way of thinking seems to be quite foreign to the problems encountered by college administrators. I have even known of an occasional psychiatrist who has been on the staff of large institutions and who could not find enough to do. This invariably means that something is not quite right, either in the attitude of the college officials, or of the psychiatrist, or both. If a psychiatric service is to be useful, there should be frequent communication between the psychiatrist and other college officials and there must be mutual confidence. A college psychiatrist is not an empire builder. It is not the function of the college to become an adjunct to a sanatorium. A college should not be expected to be responsible for long-term treatment of its students. In a sense, the psychiatrist should be working to make his services unnecessary. Unfortunately that looks like only an ideal for the next few decades at least. There are some areas of education, notably law, where the study of human behavior, as the psychiatrist views it, is rather rigorously excluded. This seems to us a little peculiar in that law is the profession that is most intimately concerned with disturbances in interpersonal relationships.

The psychiatrist is most useful in a college when his acceptance by other faculty members and by students is such that he may serve as an additional agency in the structure of the institution, which is working toward the attainment of emotionally mature points of view in all concerned. In such a position, he must be as ready to learn as he is eager to teach. Only when he functions more or less as a catalytic agent in the process of education for emotional maturity is he being used to the greatest advantage. It is to be hoped, however, that in the process he, too, will be changed for the better.

OF FENCES AND NEIGHBORS

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IT is a psychiatric truism that many of the handicapping attitudes that afflict our adult lives are archaic performance patterns laid down in the misty recesses of our childhood development—patterns that were at least understandable at their inception and perhaps entirely appropriate to the realities of past circumstances long since obscured by the sedimentary deposit of daily existence. For reasons closely linked with the intensity of our past emotional responses to the conditioning event or to the whole complex of its attendant circumstances, we “forget” the how and the why, but keep an attitudinal memento of the experience with us like the bronze castings of our baby shoes into which our adult feet can never realistically hope to fit. Fears associated with the sticky-fingered theft of a cooky from the kitchen shelf are anachronistic when they influence decisions at a corporation’s board meeting. Unresolved resentment at an unjust paternal reprimand does not smooth relationship with a supervisor who must direct our energies.

Society itself is no stranger to incongruities of this kind. It is relatively easy for us to smile at the rows of useless buttons on the sleeves of a man’s jacket, identifying them as the mummified insignia of a forgotten past. It is far more difficult to isolate the cultural anachronism which touches our prejudice, our ignorance, or our pride. In bequeathing our mother’s gold ring or our grandfather’s home farm, the past modifies the pattern of our character little, if at all. Nor can we persuade ourselves that to-day’s vast legacy of scientific knowledge exerts any truly significant influence upon the essential structure of our personalities. Homer sang his epics, Alexander spread his conquering hand over much of the earth’s surface, and Marcus Aurelius wrote his penetrating commentaries with no sense of technological deprivation and with no sequent mutilation of the product of individual

genius. Far more vital in human terms are the inherited institutions of that particular civilization into which we are accidentally thrust by the obstetrical whim of creation, the fetishes, the taboos, and the folkways of the world as we find it. We are slowly learning something of the self-perpetuating nature of these hardy cultural perennials and have acquired a new respect for the psychological infectivity of the social environment, duplicating and reduplicating itself as generation succeeds generation. Just as the dimly remembered mores of our parents' nursery days reflected the accumulated expectations of ever more remote cultures, so will our own children sense and conform to the "inherited" atavisms which we unconsciously impose upon their development.

The identity of the man who invented the first fence has been forgotten for unnumbered centuries, yet it would be interesting and perhaps revealing to speculate on the temperament of this ancient, stained with the muck of Cenozoic swamps, infinitely remote in human time, yet remarkably definable in our imagination. We know he was no fool. He had memory, ingenuity, and foresight—memory to trace out the pattern of past evil; ingenuity to conceive a practical course that would safeguard him and the objects he valued against depredation; foresight to see that tomorrow would resemble yesterday. We know he was acquisitive, cautious, thrifty, and conservative, and we can assume, within the limitations of the environmental situation, that evolutionary influences tended to place a premium upon those very qualities in his descendants.

We know also that Nature's inflexible accounting practices have always entailed a debit for every credit, and that our antique inventor must have paid for his survival with shuddering attacks of fear, with mounting anxiety, and with an all-pervasive suspiciousness. In time insecurity assumed congenital proportions. As his grasp of contingencies broadened, it became increasingly difficult and finally impossible to accumulate sufficient treasure *within* his fence to allay his concern for the future. With the waxing of intelligence and the burgeoning of imagination, fancied terrors and nightmare fears far outstripped in malignancy the world's harsh practical dangers. Entering the race for ever higher, ever better fences, he discovered the paradox

that each improvement in defense offered a lessened assurance of safety. The chimeras of anticipated dangers multiplied faster than his production of effective personal antidotes.

Somewhere along the developmental scale, he hit upon the ingenious security operation of multiplication. If he were two, he would be twice as strong. If he were four, four times as rich. If he were eight, eight times as safe. The idea of the *in-group* was born, not as a collaborative social venture in which the individual voluntarily participated, in which the unique was valued or the aberrant accepted, but as a rigidly circumscribed, tightly fenced, mutual-protective society, monstrously intolerant of difference within itself and compulsively hostile to all beyond its boundaries.

Just as "in" is a polar word which loses its meaning in the absence of the antonym, so, too, an *in-group* can exist only in terms of an *out-group*. The goal of its members must be identity. Elaborate safeguards must be employed to relegate all difference to the Cimmerian regions beyond the ever-heightening fence. Immense communal value is accorded to the same temperamental qualities we have postulated for our solitary inventor of the fence, while the same penalties, in the coin of anxiety, suspiciousness, and fear, are exacted in compound form. Such groups are in reality pseudo-societies to the exact degree that they succeed in the attainment of their aims, just as the endlessly reflected image of a single man standing in a hall of mirrors can be thought of as a pseudo-crowd.

The effective society is always oriented to reality. It may find itself in necessary conflict with the aims of another cultural group or, after a realistic weighing of objective dangers, in actual need of fences, real or emotional. At no time will it depart for long from its primary concern with the common good or neglect its search for means to defend the divergent interests of its members against the malignant action of internal visionary influences.

The issue that concerns us here is, in contrast, oriented only toward unreality, and epitomizes one of the most unhappy defects of *in-group* psychology. It is a very specific, very ancient, and very useless social barricade, the atavistic demon fence that encircles those unfortunates in our own

culture who suffer from mental illness. The twentieth-century perpetuation of such a fence is being directly challenged today and we can, at least, take some pride in the gradual disappearance from the physical boundaries of our mental hospitals of its actual concrete and steel manifestations.

The really troublesome barrier lies, however, within men's minds, and it is here that its pickets of superstition, fear, prejudice, ignorance, and intolerance wreak their havoc. We have come to an uneasy acceptance of the mortality of the flesh, and for a century or two have refrained from stoning the hunchback and the leper. We have yet to face the threatening realization that vagaries of the mind and disorders of the emotions are similarly a part of the human lot. Although we have stopped burning our psychotic fellow men at the stake for their effrontery in becoming ill, we are not quite ready to bring them the same measure of loving concern we easily accord the cripple and the paralytic.

The fence that separates us from an empathetic and perhaps helpful relationship with the mentally and emotionally ill was intended to protect us from the fantastically exaggerated hazards, real and psychological, that contact with these unfortunates was believed to entail. An interesting, although not too surprising, testimony to the skill with which the barricade was erected is that now, when we are far more ready than we have ever been to try to understand and help, we occasionally find that mental-hospital staffs view our fumbling efforts with reserve or open suspicion. The progressive removal, then, of this barbaric fence may involve not only steady and sustained efforts on the part of the community, but also the development of new patterns of feeling by those dedicated individuals who, in their careers of service to the psychiatric invalid, have acquired an inappropriate defensiveness which can no longer discriminate between past rebuffs and honest present concern.

Indignant social demands for corrective action, when some shocking revelation is made regarding conditions in a mental hospital, rarely result in anything more than the reshuffling of a few harried political appointees, while the intermittent enthusiasm for good works that affects all of us temporarily under the influence of a persuasive movie or a best-selling

psychological novel hardly offers a permanent solution to the knotty problem with which our culture is faced.

Undoing the deeply instinctive work of our remotest ancestors can hardly be accomplished within the tick of Eternity's clock accorded us, yet neither the magnitude of the task nor its difficulty need discourage those who remember the sage Chinese axiom that a journey of ten thousand miles starts with a step. That first step can often be taken by representatives of the community's mental-hygiene society. Nothing more complex than a call on the mental-hospital superintendent with the question, "How can we help you do your job?" may be the beginning of surprising things.

Perhaps the most common error the well-intentioned organization can make in this connection is to think in terms of *things* rather than of attitudes and services. It is comparatively easy to organize a bazaar, contribute to a fund, or persuade some local merchant charitably to reduce the price of a television set for the patients on Ward A. Although such material assistance is welcomed by all hospitals, it is by no means the kind of help they most desperately need. The distinction is essentially that between giving a hungry family an occasional basket of food and restoring their self-respect through vocational training, social counseling, productive employment, and community reintegration.

A second frequent error is more subtle, but equally troublesome, and involves the singularly widespread conviction that each of us knows the specific cure for the other man's difficulties. The very woman whose total concept of an automobile is of a mass of metal that is pushed here and twisted there to make it move, the very man who candidly admits his complete bewilderment before the minor complexities of a radio set may—with no other basis for their belief than the conviction itself—conceive of themselves as superbly competent in grasping and solving every human problem. Their panaceas are characteristically reduced to such concise bits of philosophizing as, "Take it easy and you'll be all right," or, "Buck up. It's always darkest before dawn," or that amazing admonition which must be widely believed because it is so often spoken, "It's all your imagination. Just use your will power and you'll snap out of it."

An almost compulsive avoidance of vainglory, a fitting

modesty before the bottomless riddle of personality, and a decent respect for the knowledge of those who have spent a lifetime in one of the most difficult and disquieting fields of human endeavor—all these, when coupled with a firm insistence that the future must be made better than the past, are necessary qualities in the individual who will help most in the destruction of our demon fence.

There is a hospital in one of the plains states which has for years received its patients from widely scattered geographic areas. Visiting days—valuable to the professional staff in securing necessary background information, to the patients in terms of emotional reassurance, and to the families in relieving their anxieties—were major emergencies which had to be regularly struggled through each Tuesday and each Thursday every week of the year. Since baby-sitters are not easily come by on farms, many of the patients' families were obliged to bring with them on their hospital visits children and grandmothers, cousins and aunts. The problems of food, of a clean diaper, of the irritability of fatigue, and of the healthy restlessness of youth were regularly laid on the hospital doorstep, harassing the staff, and not infrequently turning confusion into frank chaos.

A community organization took over. An inexpensive, but charming nursery was erected near the entrance to the hospital grounds and the surrounding area was developed as a fenced playground for older children. A motherly woman wise in the burping of babies and appropriately commiserative in tricycle accidents was employed and placed in charge. She was assisted by a panel of volunteers from the community, each of whom devoted a half-day a month to the work. A men's club provided the playground equipment and a steady supply of toys. Another club saw to it that there was always food for hungry young appetites.

A small city in the Mississippi Valley, where the searing mid-continental heat of summer is wonderful for corn and dreadful for human beings, was famous for two things—the largest mental hospital and the finest public park in the state. The particular seasonal virtue of the latter was a splendid, spring-cooled swimming pool, shaded by trees and largely filled with the ambulant population of the town during the worst of the summer weather. A good many years

passed before the demon fence was breached, but when a small group of thoughtful townspeople managed it, buses from the city's transit company were chartered for two afternoons a week throughout the summer. Volunteers helped the meager hospital staff in the tasks of supervision, and load after load of sweating, miserable patients were given a chance to feel the relief of a cool dip and, perhaps even more important, the interest and the concern of a world from which they may have had good reason to believe they were excluded.

Since hospital afternoons at the pool were restricted to patients, it would be of interest to speculate on the psychological reaction of the entire citizenry thus reminded twice a week that its voluntary sacrifice was contributing to the comfort of men and women about whom it had done little thinking before. Whatever the connection, the superintendent was impressed by the community's heightened interest in the hospital after the inauguration of the swimming program and by a decided increase in requests to help in other ways.

A New England mental hospital had been riddled by scandals, investigated by the state's attorney, and cited by the press as an outstanding example of mismanagement and inefficiency. Public relations were at what appeared to be the lowest possible ebb. The familiar politically-inspired shake-up in the administrative staff occurred and the superintendency was offered to a psychiatrist who, before accepting the appointment, called on the governor and, in effect, stated his terms. When these were agreed to, he moved into the situation. Months of untiring effort lengthened into years as a hospital was laboriously created out of a disreputable institution. It would be impossible to detail the almost endless succession of problems that were faced and mastered, but the new superintendent's first action on assuming his duties does merit our particular attention.

He made an appointment with the editors of the city's two newspapers and, with a frankness with which they were probably unfamiliar, outlined his broad purposes. He invited both men to visit the hospital at their convenience, promising to show them every ward, every cranny, every pesthole. He offered the flat assurance that they or their authorized representatives would be certain at all times of the same reception

and of identical access to all parts of the hospital for as long as he remained in charge. He told them further that he would personally take the responsibility of informing each paper of every injury to a patient in which there was the vaguest suspicion of mistreatment, of every disciplinary action against an employee, of every discharge for cause, of every escape, immediately after he had himself learned of the fact. He shook hands, put on his hat, and left in what one can infer was a silence of total disbelief.

The singular thing was that he did precisely as he had promised. From these small beginnings and against the most serious odds, he struggled tirelessly for community recognition and finally won both the respect of the townspeople and acceptance for his hospital. Years later, when a new and venal state government found him less malleable than was desired in connection with the hospital appointment of certain devoted, but otherwise unqualified party workers, it was noted that efforts to discredit him met with almost savage retaliation from the local press, the chamber of commerce, various citizens' leagues, the board of education, and a large number of businessmen's clubs. The community had taken responsibility for its own.

One hospital makes a practice of opening its doors to the annual meetings of the state's medical societies; another, through the joint efforts of the community and the staff, has established a clubhouse in which the local chapter of Alcoholics Anonymous regularly meets; a third holds monthly dances, with partners of both sexes driving to the hospital from a neighboring college. Several states have well-organized and growing programs for family care, and important work is going forward in a number of areas looking toward the economic reintegration of discharged mental patients in the factories and business establishments of the vicinity.

Some hospitals publish magazines in which articles by ex-patients and staff members are presented, discussing problems common to large groups of the sick as well as to many who will never require psychiatric care. Volunteers take patients on outings and to football games, while an increasing number of communities provide hospitalized patients with such intramural services as instruction in music, handicrafts, and the pictorial arts.

The demon fence that surrounds the psychiatric patient and that is seen in its most distressing form about our mental hospitals can be destroyed only with much effort and great good will. It receives its mortal blow when, along with our suspicions, our fears, and our disgust, we abandon our Pharaical pride in freedom from the "stigma" of mental illness; when we begin to take the same proprietary pride in our mental hospitals that we do in our high schools; when we finally open our hearts to the homely old satisfactions of being good neighbors.

THE DETROIT SCHOOL MENTAL- HEALTH PROJECT

A FIVE-YEAR REPORT

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FOREWORD

THE project in education for mental health here reported was conducted in the years 1947 through 1952 in Detroit and surrounding communities. It was sponsored by the Committee on Mental Health in the Schools, with the aid of certain units of Wayne University and the University of Michigan. It was designed primarily to help teachers make the school environment even more likely to conserve and promote the mental health of children.

Publication of the report was decided upon in the belief that the experiences described can be of value to school administrators and college officials in conducting activities for fostering mental health in the schools.

No space has been used to explain the importance of mental health. Informed school people are already aware of the far-reaching consequences of the lack of mental health and the need to do everything possible to insure its development.

We wish to express our great appreciation for continuing interest and assistance to the two sponsoring universities, to the other educational and social-service agencies that participated, and to the school systems of the metropolitan Detroit area.

We are grateful for the financial support given throughout the five years by McGregor Fund and the Children's Fund of Michigan and, for one year, by the Kresge Foundation.

Numerous individual psychiatrists, psychologists, educators, and social workers brought to the project high competence in various aspects of mental health. Without the quality of

their participation as staff members, the program could not have been as effective as it was. To them we are truly grateful. We wish to acknowledge particularly the services of Dr. William W. Wattenberg as coördinator for many of the courses and institutes, and as educational consultant on the program.

The project is being continued.

Probably the ideal way to improve mental health in a community like Detroit, and particularly in its children, would be to establish resources whereby all the parents could help themselves to strengthen their own mental health as self-developing beings. There seemed to be too many parents to reach with the available staff and materials. Teachers were chosen as the next best group through which to raise the level of mental health in the community. Teachers are with children from ages five through seventeen for about twenty-five hours a week. Next to parents, they probably have the greatest influence on children's growing minds—for good or for ill. Since there are only about twelve thousand of them in the metropolitan Detroit area, the task of reaching them is not insuperable. It is the teachers, then, around whom this project has been organized. We have tried to work with them toward the correct comprehension and fostering of mentally healthy school living.

Recent Progress.—The public schools of Detroit and the metropolitan area generally have made a number of significant gains in the field of mental health during the past twenty-five years. First, the new teachers of to-day have much more training in child development and mental health than the new teachers of twenty-five years ago. Second, there are now more special personnel in the schools to work with individual pupils who have problems. These include visiting teachers, psychological-clinic staff, attendance officers, attendance teachers, and counselors. Third, there is more direct teaching of the principles of mental health to children through health-education textbooks, the classes in homemaking, and the classes in family living offered in the intermediate and senior high schools. Fourth, the schools—particularly in Detroit—have an active program of intercultural education and human relations under the continuing sponsorship of teacher com-

mittees in almost all schools. The latter program stresses the importance of people's feelings and supports the mental-hygiene value from another approach.

The Planning Committee.—In the spring of 1947 a local planning committee, representing professional education and psychiatry, was set up to consider next steps for the schools. The committee included about twenty principals, supervisors, psychologists, and other school people, and eight psychiatrists. The group devoted seven evening sessions to the discussion of the whole problem of mental health in the schools and to the drawing up of plans to improve the situation still further. Additional meetings of this group have been held once or twice a year since then for the purpose of reviewing accomplishments and revising plans.

Purpose.—Three rather different proposals for a program for the schools were discussed originally. One was to train teachers to identify the youngsters who most need special help from the visiting teacher, the child-guidance center, or the psychiatrist. Another was to help pupils understand themselves better and to learn something of the principles of mental health—a purpose to which the growing program in education for family living contributes. Both these ideas were acceptable, but it was felt that the most important purpose was to help teachers and school administrators make the living conditions in the school and the classroom more conducive to the development of mental health in the pupils and staff members participating.

Assumptions.—The underlying assumption is that the schoolroom environment will be most conducive to mental health when teachers revere individuality, their own and that of every child (and other person), when they understand how they and the children grow and develop, and when they have skill in discovering and meeting their own basic needs and those of the individual children in their care. Acceptance of children as they are seems essential to their betterment. Teachers are most likely to promote mental health in those associated with them when they truly appreciate that every person's behavior, however relatively harmful, is necessary for that person under the existing circumstances and is the best of which he is capable at that particular time. When a child feels that he has such sympathetic understanding and

encouraging support from his teacher, he will have a real motivation to change himself; he may then be ready for help.

The program is built on the assumption also that teachers can receive help from many different sources—primarily the children themselves; colleagues on the school staff; writings and talks by psychiatrists and other specialists; and films, radio transcriptions, and plays that illustrate the principles of mental health. Heavy reliance has been placed on psychiatrists in the hope that some insights like theirs into human nature and maturation may be developed by teachers.

The Program.—During the five-year period the program has been continually developing, with new approaches and changing directions appearing from time to time. The first major outcome of the deliberations of the planning committee was a proposal for a special course in education for mental health as the most practicable way of reaching large numbers of teachers. It was recognized, however, that books, bulletins, and periodical materials also had a contribution to make.

It was recognized early in the program that not all the teachers in the metropolitan area would take the special course that had been planned. Many of them had taken or were taking other courses on mental health offered by the collegiate institutions in the metropolitan area. Many had other interests and obligations that kept them from giving up an evening a week for a semester. It seemed desirable, therefore, to use other supplementary approaches. One such was what was called an institute, of two or three sessions. Another approach was a series of radio programs presented at the time of the regular teachers' meetings. Still another was the study of the implications of group dynamics for mental health. In this connection attention was given especially to the psychodrama and rôle-playing. Lastly, one-act mental-health plays were used extensively during the fifth year of the program to present the ideal of self-growth with self-insight through yet another medium.

The Beginning Course.—At the outset the Committee on Mental Health in the Schools arranged with the University of Michigan and Wayne University to sponsor and offer jointly a new course in education for mental health. In each institution both the college of education and the department of

psychiatry of the college of medicine participated. The Extension Division of the University of Michigan also coöperated. The course was scheduled as a regular class, meeting one evening a week for sixteen weeks, and gave two hours credit, either graduate or undergraduate. The committee secured grants from local foundations and used a part of the money to subsidize the course to the extent of paying \$8.00 of the tuition cost for each individual teacher. This subsidy was made in order to encourage registrations.

Each class session lasted for two and one-half hours and the time was scheduled to provide for the use of varied techniques. During the first half hour, the entire group were in the auditorium to see films and hear transcriptions of radio programs that dealt with various aspects of human relations and mental health. The next hour was used by a psychiatrist experienced in work with children to present in lecture or panel form the essentials of child growth and the principles of mental health as related to the work of the teacher in the classroom.

For the final hour the class was divided into discussion groups of about thirty or thirty-five members, each under the leadership of a specialist in child growth and human relations. In these small groups the teachers brought up their classroom problems and secured the help of other teachers and of the discussion leader. About every third session, each discussion group had a psychiatrist available as a consultant. Readings were suggested. Each student who took the course for credit was required to submit a term paper which might take the form of a description of one of his pupils whose behavior or attitudes constituted a problem in the classroom. Or the term paper might be a report on some special topic in the field of mental hygiene, intensive study of which the teacher felt would be beneficial to him.

The content of each course varied in accordance with the experience and interest both of the instructors and of the teacher-members of the class. In general the psychiatrist-lecturers included such topics as "The Prevalence of Mental Conflict," "How the Psychiatrist Views Problem Behavior," "The Influence of the Family Constellation," "The Effects of Immediate Preschool Experiences," "The Impact of School on the Child," "Pre-Adolescents and Their Problems,"

"Development in Adolescence," "Which Children Need Special Help," "Resources for Special Help and How to Use Them," "Nervous Habits," "Aggression and Hostility," "Withdrawing Behavior," "Authority Relationships in the Lives of Children," "Group Atmosphere in the Classroom," and "The Rôle of the Teacher."

The films were chosen to fit in with these topics as completely as possible. The discussion period was devoted to the application to classroom situations of the observations of the psychiatrist. In these discussions teachers were encouraged to present some of their classroom problems for the consideration of the group.

Staff members were sought primarily from the personnel of the colleges of education, medicine, and social work of the two sponsoring universities. Because of the pressure on instructors from other activities in their institutions, many additional persons had to be secured on a part-time basis. This was particularly true of psychiatrists; in consequence, many psychiatrists in private practice in the Detroit area were involved. Likewise, social workers, psychologists, and visiting teachers from social agencies and school systems and institutions of higher learning were selected to serve as discussion leaders. Staff members were paid by the universities in the same manner as for other courses.

For each class, one discussion leader was selected to serve as coördinator. He took responsibility for getting the course organized, for handling registration and records, for selecting the films, for scheduling the psychiatrist-lecturers, for assignment to discussion groups, and for general conduct of the course. He also acted as chairman for the general sessions. He introduced the films and speakers, moderated any panel discussions, and conducted the question period.

A major problem was that of the development of the most effective rapport, especially with the psychiatrist-lecturer and with the teachers in the class. Psychiatrists were usually unacquainted with day-to-day teaching situations in elementary and secondary schools. At first they had difficulty in adapting their presentations to the needs of the teachers. Teachers pressed for specific answers to specific problems they faced. The psychiatrists were hesitant to prescribe specifics without full knowledge of the individual situations

presented, and this was not possible. Consequently there had to be a continuing effort to have the teachers accept the psychiatrists' purpose to clarify the concepts of the process of child growth and development and of the dynamics and rationale of problem behavior, in order that teachers might achieve a fuller understanding of their own pupils in relation to mental health. At the same time the psychiatrists had to adjust their thinking more specifically to the group situations in which teachers work. In general, it seems fair to say that the mutual adaptations by both groups worked out quite well. The discussion-group leaders, having both teaching experience and training in mental health, were able in the discussion period to help bridge the gap.

There were other problems. Parking was difficult because of the size of the groups involved. Locations for the classes were chosen, however, to facilitate parking as much as possible. A greater problem arose from the fact that the class was held in the evening after a full teaching day. Since teachers came long distances from various school systems, the evening hour appeared to be the only practicable period at which a sufficient stretch of time could be obtained.

An unusual feature, during the first three terms the course was offered, was the weekly staff conference at which the entire staff ate dinner together just before the class session. The psychiatrists and the discussion leaders thus were able to share their experiences and to plan better the use of the time in the lecture and discussion periods.

During the first three years, the course was set up separately for teachers in elementary schools and for teachers in secondary schools. Later, both elementary and secondary school teachers were admitted to the beginning course. From the outset, principals and supervisors and superintendents, as well as classroom teachers, were invited and encouraged to enroll. All through the five-year period the course was publicized extensively by printed and oral announcements, not only in the Detroit schools, but also in the other school systems of the metropolitan area within a radius of thirty miles or so. On several occasions the course met in schools outside the city of Detroit. Excellent coöperation was given by the principals and administrators of the Detroit public-school system, and by the superintendents of schools throughout

the metropolitan area. The large numbers of persons enrolled in the course were due in great part to the interest and support thus expressed by school administrators throughout the area.

From September, 1947, to July, 1952, the course was offered fifteen times, with enrollments as indicated. A total of 2,856 teachers took the class, about two-thirds of them for college credit and one-third for no credit. Enrollment was voluntary.

Fall, 1947	— Elementary Teachers, Rackham Building	762
Spring, 1948	— Elementary Teachers, Rackham Building	397
Fall, 1948	— Elementary Teachers, Central High	270
Spring, 1949	— Secondary Teachers, Central High	123
Spring, 1949	— Secondary Teachers, Cooley High	128
August, 1949	— Elementary Teachers, Wayne University	97
Fall, 1949	— Elementary Teachers, Central High	158
Fall, 1949	— Secondary Teachers, Barbour Intermediate	93
Fall, 1950	— Elementary Teachers, Central High	121
Fall, 1950	— Secondary Teachers, Condon Intermediate	47
Spring, 1951	— Elementary and Secondary Teachers, Central High	80
Spring, 1951	— Elementary and Secondary Teachers, Berkley High	172
Fall, 1951	— Elementary and Secondary Teachers, Denby High	92
Spring, 1952	— Elementary and Secondary Teachers, Central High	150
Spring, 1952	— Elementary and Secondary Teachers, Waterford Township High	166
Total enrollment in beginning course		2,856

A check was made of the enrollments in other classes in mental hygiene offered at Wayne. It was found that the enrollments in these other courses were actually higher in the four years following 1947 than in the four years preceding. It seems probable, therefore, that the more than 2,800 teachers taking this special course were mainly persons who would not otherwise have taken a course in this field.

Follow-Up Appraisal of Beginning Course.—How did the many teachers who took it react to this course? In order to get some evidence on this question, a questionnaire of forty items was devised and sent out in June, 1948, to teachers who had completed the first course in January, 1948. This questionnaire was sent out also to members of each succeeding class about six months or so after its completion. Replies were sent in unsigned and unidentified. The first two sections of the questionnaire dealt with "Your Relations

with Pupils" and "Your Relations with Others." The teachers were asked to compare as honestly as they could their practices then, six months after completing the course, with their practices a year previous, before taking the course. The replies¹ showed that the great majority felt that their relations both with pupils and with other adults were definitely better from the point of view of mental hygiene on practically all the specific points covered by the questionnaire. Teachers believed that they had changed more in their relations with pupils, however, than in their relations with other adults.

The third section of the questionnaire dealt with "Your Reactions to the Course Now, After a Period of Time." About 95 per cent of the teachers answered "Yes" to the question, "All things considered, are you glad you took the course?"

A key question in the inquiry was, "What do you think was the main change in you by taking the course?" Here are some fairly representative answers:

"I am more likely to accept each child as he is."

"I felt more adequate in many situations which were previously difficult."

"I became more tolerant of my pupils' and co-workers' ideas and behavior."

"It sort of 'smoothed out' some of my tensions."

"I pay more attention to the quiet child."

"I don't make so many snap judgments."

"I cannot detect any major change."

"I think I understand myself better."

"I try to give more to the child who needs more because of his lack of parental guidance and understanding."

It is fair to say that the changes most frequently mentioned in the replies were these: more heedful self-observation, a feeling of greater understanding of children, greater patience with them, and greater desire to meet children's basic needs.

No systematic effort was made to find out from principals, supervisors, or others in contact with teachers who took the course what changes, if any, they observed in these teachers.

¹ See, for example, *Follow-Up Evaluation of Beginning Course in Education for Mental Health—Spring 1949, Fall 1950, and Spring 1951*, by Paul T. Rankin. Heetographed manuscript, 1952.

Many informal comments were heard, however. In general they substantiated the statements made by the teachers themselves. Thus, principals often said that, after taking the course, Miss X was more humane to her pupils, or sent fewer pupils to the office, or seemed to get along better with the parents. The casual comments picked up from visiting teachers were usually to the effect that teachers with whom they worked and who had taken the course were able to deal better with particular children who had problems. Both principals and visiting teachers said that they believed children with problems were being referred earlier by teachers who had been in the course.

The Advanced Course.—The proposal made by the planning committee in 1947 was a single course. Before the first course ended in January, 1948, however, a number of those in attendance expressed a desire for a further course in this area. Many said that they had just got started. Similar expressions came from members of the class the following two semesters. In consequence, an advanced course was offered in the spring semester of 1949.

A new pattern was developed for this advanced course. In order to keep before the teachers the point of view and special preparation of the psychiatrist and at the same time to insure awareness and cognizance of school practice, a team of two instructors was provided—a psychiatrist and an educational psychologist. The class met for a two-hour period, and usually was about double the size of an average college class—approximately seventy members. Ordinarily the entire group stayed together for the full two hours, with both instructors present. Heed was given in the discussion to the problems on which teachers wanted the help of the psychiatrist and the psychologist.

At the end of the five years, 558 of the teachers who had taken the beginning class had taken also the advanced one. As in the case of the beginning course, the elementary- and secondary-school teachers met in separate groups during the first several years of the advanced course. Later, elementary- and secondary-school teachers were intermingled in the same class. In order to make attendance as convenient as possible for the teachers, the course was offered in different localities both in and out of Detroit.

From September, 1947, to July, 1952, the advanced course was offered six times, with enrollments as indicated:

Spring, 1949 — Elementary Teachers, three different sections	224
Spring, 1950 — Elementary Teachers, Wayne University	75
Spring, 1950 — Secondary Teachers, Wayne University	45
Spring, 1951 — Elementary and Secondary Teachers, Central High	85
Fall, 1951 — Elementary and Secondary Teachers, Berkley High	63
Spring, 1952 — Elementary and Secondary Teachers, Highland Park Curriculum Laboratory	66
 Total enrollment in advanced course	 558

Brief Institutes.—It became clear during the third year of the project that it probably would not be possible to get all the teachers of the metropolitan area into one of the full-semester courses in education for mental health. The enrollment in the regular course, though still substantial, had decreased each year. Accordingly plans were made, in the fall of 1949, to offer institutes, or very brief courses, for teachers grouped either by position or by geographical proximity to one another. The purpose was to put into three sessions the heart of the entire course and thus bring the principles of mental health to a much larger number of teachers. It was hoped also that attendance at the brief institutes would stimulate interest in taking the full course later.

The general pattern for the institutes was three weekly sessions of two or two and one-half hours each, held either in the late afternoon or in the evening. In each case a psychiatrist served as the lecturer, and in most cases one or more psychologists or social workers were assigned as discussion leaders, with one discussion leader acting as coördinator. The typical schedule was a half-hour for a film, an hour for a lecture by the psychiatrist, and an hour for discussion in small groups under the leadership of persons qualified in education for mental health. As in the case of the classes, attendance was entirely voluntary.

Some of these institutes were set up for groups chosen on the basis of common professional interest, such as the elementary-school principals, sponsored by the organization, Elementary School Principals of Detroit; the superintendents of the metropolitan area, sponsored by the Metropolitan Detroit Bureau of Coöperative School Studies; the school-

cafeteria managers; and the special-education teachers of Detroit. In an institute thus organized it was possible for the psychiatrist and the discussion leaders to direct the presentation and discussion in terms of the specialized problems and interest of the particular group of educational workers for whom the institute was planned.

Other institutes were organized on a regional basis. Most of them were conducted for the teachers in the eight elementary-school districts into which Detroit is divided. Each district consists of twenty-five to thirty elementary schools, with approximately six hundred teachers. Usually the institute was sponsored by the principals, the supervising principal, and the district committee and individual school committees on democratic human relations. In most cases the sponsors made quite an occasion of the institutes. Tea and cookies were provided for a brief social period preceding each session, making for good feeling and compensating somewhat for the fact that the institutes usually came at the end of the teaching day.

The pattern of three sessions was not an unvarying one. Some groups had an institute for an entire day. Other groups had one or more sessions for an entire afternoon and evening.

The institutes constituted a successful means of bringing the subject of mental health to the attention of a great number of teachers. There were twenty-seven different institutes with a total of 3,680 teachers and principals and administrators involved. No formal attempt was made to appraise the reactions of those who attended the institutes. Informal comments of many participants, however, indicate that, in general, teachers felt that they had secured new help in conducting their own classes more nearly in accordance with the principles of good mental health.

Special Activities.—In order to reach teachers who had not attended the special courses or one of the institutes, a series of four radio programs was conducted in the fall of 1950. This was presented over the Detroit public schools' own FM station, WDTR, from 3:30 to 4:00 P.M. on Tuesday afternoons at two-week intervals. The time was set to coincide with the regular elementary-school teachers' meetings and the time of many secondary-school teachers' meetings. Principals were asked to have the radios turned on in the teachers' meetings for

that half-hour, and then to encourage discussion afterward. Each program consisted principally of a talk by a psychiatrist, with comments on questions raised by a representative Detroit teacher. The best estimate that can be made of the size of the listening audience in the teachers' meetings in Detroit is about five thousand.

A second special approach was the provision to one school of the services of a psychiatrist for one afternoon a week for most of the first semester of 1950-51. The teachers of the school had been informed that the psychiatrist would be available and had indicated their willingness to have him in their school. He spent the period from 2:00 until the close of school in visiting classrooms, usually at the request of individual teachers. After school he met with those teachers who wished to stay to get his comments on what he had observed and his answers to any questions they might raise.

The principal effect on the teachers seemed to be an increased assurance on their part with regard to their jobs. They said that they felt better after they had talked with the psychiatrist. They welcomed the help he gave in discussing his ideas which he related to some of the individual children about whom they were especially concerned.

The psychiatrist made an extensive report of his reactions to the experience. He thought the hardest concept for the teachers to accept was that of character formation—the necessity of acknowledging being what you are, as a requirement for further growth. Another principle difficult for them to accept was that the effective procedure, instead of their beginning with the pupil and trying to modify his character, was to begin with themselves and their inability to tolerate the pupil. He felt that his presence in the school made it possible to define teachers' needs better, but that it was difficult to work out the best use of the psychiatrist as a consultant in the school. He stated that at times the mental-hygiene classes present materials that the teachers are not ready to work with, and consequently defeat their purpose. He concluded by saying, "I believe our aim should be to pay attention to the mental health of the teacher and her school family, respecting her for what she is and attempting by the best means possible to help her on the spot in the school setting to gain some insight. Attention should be

directed to helping her use her human qualities artistically."

A third special activity was the consideration of the possible contribution of group dynamics, including the psychodrama and rôle-playing, to teacher understanding and to the improvement of school conditions. Four of the so-called institutes were thus pointed. In two of them a team of psychiatric social workers from Pontiac State Hospital discussed their use of the psychodrama with patients, and illustrated their procedure in dramatic form. A specialist in rôle-playing in therapy conducted the institute for teachers of family living in order to show them how rôle-playing might be used in their classes to help children understand themselves and others better. Similarly two specialists in group dynamics conducted a one-day session of sixty principals to show how rôle-playing might be used with adults to give a better understanding of other people's feelings.

The institutes for superintendents, for secondary-school principals, and for elementary-school principals differed from the general institutes in that the focus was on relationships among adults, and particularly those of administrators and teachers.

Another type of activity which proved to be of considerable value to the participants was the trip to the Children's Unit of the Neuropsychiatric Institute at the University of Michigan Hospital. Two groups—visiting teachers and psychological-clinic workers on one day, and seventy elementary-school principals on the other—spent a half day there. The psychiatrist in charge described general procedures in working with disturbed children. He then had different staff members describe particular cases, telling what they had found out about how illness occurred and how it might be treated.

Films and Recordings.—Both the classes and the institutes made extensive use of appropriate films and transcriptions of radio programs. The usual procedure was to have a brief introductory statement by the coördinator, pointing out some things that should be noted particularly; next to present the film or transcription; and then to have some interpretative comments by the psychiatrist or the psychologist. In some instances, when there was considerable interest, time was taken for a general discussion of what had been seen or heard. No use was made of film forums made up exclusively of films

and accompanying discussion, although there are indications that this might be a good approach to add to those used.

Some of the films that have been used most frequently and that appear to be of greatest general value in the classes and institutes are: *Feelings of Depression*, *Feeling of Hostility*, *Feeling of Rejection*, *Emotional Health*, *The Okinawan*, *This is Robert*, *Children Growing Up With Other People*, *Meeting Emotional Needs in Childhood*, and *Palmour Street*.

In the early phase, transcriptions of the *Doorway to Life* radio series were made available by Station WJR, and were used quite extensively. Transcriptions of radio programs tended to be used less in the later years of the program, partly because of the difficulty in hearing them distinctly in large groups and partly because the members of the group did not appear to find them as helpful as the films. The Menninger recording, *Meet Your Mind*, however, was used throughout the series of classes.

Mental Health Plays.—In 1951 considerable interest developed in the series of one-act plays written by Nora Stirling, of the American Theatre Wing, for The National Association for Mental Health. These plays include the following: *Scattered Showers*, *Fresh Variable Winds*, *High Pressure Areas*, *The Ins and Outs*, and *And You Never Know*. All five are relatively easy to present, for they require no scenery or elaborate costuming. They are short, and each is directed to some one aspect of mental health. They are accompanied by excellent discussion guides prepared by Lawrence K. Frank. The presentation of the plays was made in close coöperation with the Detroit Council of Parent-Teacher Associations, where there already was some interest. The play, *The Ins and Outs*, in particular, and to some extent the others, were demonstrated in sessions for teachers of family living and were used fairly widely in the intermediate and high-school classes in family living. For this project, however, the important contribution was made by presentations at school faculty meetings and at Parent-Teacher Association meetings attended by both parents and teachers. Although the plays were designed primarily for parents—with the exception of *The Ins and Outs*, which was planned for high-school students—trial in faculty meetings demonstrated that they had real value for teachers also.

The procedure was to have two or three schools each prepare a play for presentation to its parent group. Then the school cast was invited to demonstrate the play and the discussion before groups of principals, and later before groups of representative parents from various schools in the district. As a result of this procedure, more and more schools became interested in the use of the plays. The local chapter of the Michigan Society for Mental Health was also active in promoting this program.

Materials.—One way to influence practice in schools is to stimulate and assist teachers through the provision of printed materials that carry the same kind of message as do the courses in education for mental health. Just about the time this project was initiated, the Detroit public-school system distributed to teachers in the kindergarten and the first, second, and third grades copies of the bulletin, *A Pound of Prevention*, by James L. Hymes, Jr. This pamphlet proved so useful and so generally accepted that others of equal value were sought. Among those that have been distributed since are the following: *Mental Hygiene in the Classroom*, by The National Committee for Mental Hygiene; *Teacher, Are These Your Children?*, prepared for use in the New York City Public Schools; *Teacher, Listen, the Children Speak*, by James L. Hymes, Jr.; *An Application to Education of the Needs Theory*, by Louis Raths; *Do's and Don't's of the Needs Theory*, by Louis Raths; and *Self-Understanding—A First Step to Understanding Children*, by William C. Menninger. All these booklets were distributed in quantities of one to five per school in those public schools of the metropolitan area in which interest was shown. In addition, sets of from thirty-five to fifty copies of several of the bulletins were made available for circulation in the Detroit schools in order to make it possible for entire school staffs to devote a meeting to a particular bulletin, with enough copies of the bulletin available to furnish one for each teacher. This appeared to be a particularly effective approach, especially with *Teacher, Listen, the Children Speak*.

The 1950 yearbook of the Association for Supervision and Curriculum Development, entitled *Fostering Mental Health in the Schools*, was a timely and valuable contribution and was publicized widely among the schools. Many schools se-

cured copies for their professional libraries. Copies were provided for the psychiatrist-lecturers to acquaint them more fully with school practices and potentialities.

The quarterly magazine for teachers published by The National Association for Mental Health, *Understanding the Child*, was sent to each elementary and junior high school in the metropolitan area. Thus current material on mental health in schools was furnished to the teachers at least four times each year.

The committee is convinced that these materials—and others that teachers locate themselves—are serving to direct the attention of principals and teachers to mental-health values and are providing help to those who wish to operate more fully in accordance with the nature and development of children.

Support.—The project has been financed by grants from local foundations. McGregor Fund and the Children's Fund of Michigan have made grants in each of the five years. In addition, the Kresge Foundation made a supplementary grant the first year to meet an anticipated deficit created by a greater response to the courses than had been predicted. The money—\$37,500 in all—has been expended through a special account of the Student Aid Foundation of Michigan, under the direction of the Committee on Mental Health in the Schools, consisting of Paul T. Rankin and John M. Dorsey, M.D.

Mental-Hygiene Perspective: Education by Self-Development.—Education in general and treatment for mental health in particular have the same high goal—namely, the development and integration of the individual, progress in cultivating happy human integrity. This program in education for mental health in the schools has had as its ultimate aim and objective a furtherance of human development. The direction of mental development is from within outward, and not from without inward.

There is a noteworthy lack of fundamental difference among people in the life principles they trust or the educational methods they value. Thus the basic idea, *helping one's self*, may be observed to be common to all. It applies not only to schooling, but also to psychotherapy. In the latter, which is reeducation to mental integration, the measures are efficacious

only to the extent that they serve the joyful spontaneous unfolding which all minds know in their steady growing to ever fuller maturity. The problem and aim in all education is to nourish peaceably the appreciation of the wonderfulness of one's own human being; there can and should be no other. The ideal force of self-growth is inexorable and irresistible, but mostly quiet, and apparent only to the earnest seeker for it.

Only that learning experience has healthy existence within man which he is clearly conscious of as being his very own. All of the educating action occurs in the one who is being educated. Educators have observed that what Pestalozzi meant basically by *immediate perception*, and Froebel by *inner connection*, was living self-activity and not dead imitation or mechanical copying. In Froebel's own words of wisdom, "Education should lead and guide man to clearness concerning himself and in himself"; and "The whole life of man is a life of education"; and "only that has real existence for man which has passed in and by clear consciousness, which, as it were, has been born anew in spirit, and indeed (again in the like conscious manner) was recognized not as merely isolated, but as an active member of a greater whole."

Our mental-health courses were conducted so that the teacher had some opportunity to live with his class members and thus expose himself to feeling his own need to grow better, if he would do better. Thus our special consultants grew in our educational service as self-observers. A code of school living is best conceived and upheld by the teacher who observes the classroom as a mental gymnasium for every individual in it, most imperatively including the teacher. Here each learner educates himself, with consciousness of his self-activity. All healthy life is a product of such free growth in a free-growing community. Clearly such "growing together alone" must be based on the self-enlarge ment that enlivens the insight: Love thy neighbor as thyself. Every child—and most critically the "difficult" one—needs acutely educational opportunity to feel convincingly his worth and dignity as a whole person, instead of as an incomplete human being. Neglect of development in accordance with human nature weakens and sickens.

For achieving mental health, something else entirely is

wanted than foreign implantation—namely, native self-growth, man's finding in himself the center and fulcrum of all his powers and thus the best use of himself. We regard it as particularly the American way of school life to welcome gladly every citizen's discovery that *he* is great, because only thus can he *live up* to his greatness. The pupil ideally goes to school to grow greater, with the life-enhancing awareness that the growing power is his own. There is a powerful germ of truth in the wit's definition of education as "that which remains, if one has forgotten all of the detailed knowledge he learned in school."

The teacher, healthfully conceived, is one in whose working presence the pupil finds himself stimulated to learn, excited to imagine, and, above all, invited to enjoy all of his own living, to acquire all of his life experience so that it develops his self-insight. It is indispensable to the getting of mental strength that the developing infant, child, and adult attend continuously to observation of his own life, without breaks and omissions. Only by living through our school and all other experiences in the sense of owning up to them personally do we meet our growth requirements for becoming stronger.

SUMMARY AND EVALUATION

Varied approaches have been made throughout the five-year period in the effort to help teachers and school administrators improve the school life of the child from the point of view of its usefulness to him in developing his mental health. More than 2,800 teachers took the beginning two-hour credit course in education for mental health. Of this number, 558 took a second and advanced course. Teachers to the number of 3,680 attended shorter institutes in which the same general ideas were presented, though more briefly. About 5,000 teachers, while seated in their teachers' meetings, heard a series of four radio programs addressed specifically to them. The potentialities of group dynamics for improving the emotional environment of children have been explored. A beginning has been made on the use of trips, as another means of interpreting the meaning and importance of mental health. Six different booklets on various aspects of mental health in schools have been distributed widely among the teach-

ers of the metropolitan area. The magazine for teachers published by The National Association for Mental Health has been subscribed to for the schools of the area. Films, recordings, and plays have all been used.

The project has been extensive rather than intensive. The goal was to work with as many as possible of the ten thousand teachers in six hundred schools in the Detroit metropolitan area, rather than to concentrate on the staffs of one or two schools. Even though the mass approach was considered preferable at this time and place, every effort was made to have the experiences adjusted to each individual teacher. As reporters, we are sensitive to the fact that, though ideas may be presented to several hundred in a group at a time, they are assimilated only by each individual as a self-experience in his own way.

It may be appropriate to point out some by-products of the project. One that seems to be quite clear is that teachers in this area are less likely to look upon mental illness with fear and hopelessness than they were before. Allied to this benefit is the fact that teachers are better able to bear their fear of psychiatrists, and it is believed that they will be more ready to use the services of the psychiatrist and the psychiatric social worker when these are indicated.

Another by-product is that the movement toward more attention to education for family living has been supported and extended by the increased experience teachers had with mental health through the courses and other activities. Teachers are doing more reading in the field of mental health than before, and they are encouraging the use of mental-health films both for pupils and for groups of parents and other adults.

The key question remains: Have teachers and schools changed? If so, have they changed for the better? An occasional teacher may have been troubled by some of the concepts revealed in the courses and institutes. Such teachers, however, constitute an extremely small minority of the total group affected by the experiences provided. We are ourselves convinced that many teachers involved in this program are living and teaching more than before in accordance with the principles of mental health. Teachers have more self-respect, attend more to children, are more humane, are

more considerate with their pupils, conduct themselves in such a way that pupils in their classes are able better to attend to their basic needs.

There appears to be more widespread concern about mental health, not only in the schools, but also in the community. School people are more conscious of the need for visiting teachers, child-guidance centers, and other resources in the school system and the community as a whole. More of them take an active part in such programs as those of the Michigan Society for Mental Health.

Individual schools and school systems are providing more opportunities for their teachers than ever before along the lines of mental health. They are incorporating increasingly, in courses of study and similar publications, the basic ideas relating to mental health and child growth and development. Learning experiences are being geared better to the abilities and needs of the pupils. Regular teachers' meetings are giving consideration periodically to ways of improving mental health in the classroom. Administrators and teachers both have made progress in understanding and in accepting broader viewpoints.

This is not to say that the mental-health problems of the schools of the metropolitan area are solved. Far from it. It does seem, however, that the project has contributed significantly to the goal of making the school a place that conserves and promotes mental health in the children and in the people who work there.

THE CONTRIBUTION OF THE PSYCHIATRIST TO THE SOCIAL WORKER AND TO THE CLIENT*

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THE development of relations between social work and psychiatry has been characterized by a steady growth of understanding and acceptance by each of the other's professional identity and differences. Social work has needed the contributions of the psychiatrist because of the wide prevalence of emotional disturbance among its clients, and psychiatry has needed the assistance of social work in finding and meeting its community responsibilities. Social work has incorporated into its theoretical background the point of view and a good deal of the content of modern dynamic psychiatry, and in turn psychiatry has received immeasurable help from social work in moving out of its hospital ghetto into the free air of community practice.

This close working relationship has undoubtedly also created many problems. Because of the ancient social traditions of medicine, because of the example of the authoritative aspects of the doctor-nurse relation, and because of the relative newness of social work as a profession, social work has on the whole tended to find itself the low man on the totem pole. Many social workers have felt with concern that their profession was becoming too dependent upon psychiatry, and have called for a sharper examination of the relationship as a step toward an affirmation of their professional integrity and independence. Sometimes this has been carried to the point of a complete denial of the value of the psychiatrist's contribution, and at other times it has led to an effort to constrict and delimit too narrowly the consultant function of the psychiatrist.

It is as a so-called consultant to an agency that the psychiatrist is able to make his contribution to the social worker

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and to the client. In this paper I shall raise and discuss those issues that seem to me to be particularly important for an understanding of the consultant function of the psychiatrist in a social agency. The particular questions I shall consider are the following:

1. What is the concept of consultation in general, and how does it apply to our special problem?
2. How does the function of the psychiatrist as consultant differ from the regular supervisory activities of the agency?
3. What contributions may be expected from the psychiatrist, and in what way may they be offered and utilized?
4. What are the responsibilities of the agency for providing suitable working conditions for the psychiatrist?

1. *The Consultant.*—The consultant is the outside expert who is called in to help in solving special difficulties that arise in the course of everyday practice. He is not responsible for the regular administrative or functional operation of the organization. He may propose in any area of policy or work, but he does not dispose. He may have opinions and offer suggestions in relation even to the most basic problems of an organization, such as its stated goals and objectives, but his is not the responsibility either for decision or implementation.

One may put it this way: The consultant is not a link in the chain of command. His obligations and authority need to be clear and defined, but in general they lie outside the scheme of routine organization structure. He can say, "This is what I think should be done," but he does not have to see to it that it is done. He can point out the consequences of this or that course of action, the implications of various procedures, and the advantages and disadvantages involved in maintaining or discontinuing any particular policies, but it is up to the organization to evaluate his suggestions, and to integrate them into their daily routines.

One of the strengths of the consultant is his freedom from everyday detail and past patterns of commitment. He is free to advocate a new idea or a new approach because he is not identified with the old. He can be a detached observer because he is not caught in the mesh of personal feeling and personal relations that have gathered around old procedures and policies. In particular, as long as he is not a regular

staff member, he does not have to contend with the conflict of loyalties that always entangles the conflict of issues.

When the consultant rôle is outlined in this way, it must become clear that the psychiatrist in a social agency does not quite fit the pattern. The most important point of difference is that the psychiatrist is usually employed as a regular member of the staff. His consultant function is ongoing and not intermittent; he is the inside and no longer the outside expert. This shift in the psychiatrist's situation parallels a shift in function. He is not only concerned with the solution of problems presented by clients; he is also called upon to participate in programs of staff development. In other words, the psychiatrist in the social agency functions as teacher as well as consultant. We still use the term "consultant," but we have added a new dimension, the educational function.

It is not easy to make clear just why the psychiatrist should be needed for in-service training in a social-work agency. One might think that it would have particular value in an agency employing many untrained workers, but actually this is not the case, since the most thoughtful and most fruitful use of psychiatric time has been in agencies with skilled workers and with a very high level of case-work practice. It must be quite apparent that the psychiatrist has little to offer as a case-work teacher, since after all this is not his field of competence. And yet one would hesitate to say that what he has to teach is unrelated to case-work practice.

Here, then, is a dilemma that cannot be resolved except by looking at the present trend in the relations between case-work and psychiatry from a point of view that is not embarrassed by too rigid a concept of differentiation of function between the two disciplines—*i.e.*, from a point of view that accepts the need for interdisciplinary coöperation in the behavior field, and looks for sources of enrichment and strength in such interdisciplinary relations.

2. *Supervisor and Psychiatric Consultant.*—The supervisor is responsible for the case-work practice of the agency, for implementation of policy, and incidentally for staff development. The routinization of the supervisor's rôle interferes considerably with the stimulative effects of her activities. She is interested, after all, in maintaining consistency and

smoothness of performance. Perhaps the most important contribution she can make is in helping her workers to realize their best potentialities for self-disciplined and self-reliant utilization of their skills.

The psychiatric consultant, on the other hand, does not or should not need to interest himself in the operation of the agency as such, since presumably this is being taken care of through the routine process of supervision. He should know the purposes and policies of the agency, but only as a frame of orientation. He can give his attention entirely to the immediate situation on which he is asked to consult. His field of interest includes a dynamic diagnostic impression of the client, an understanding of the worker-client relationship, and an awareness of the problems of the worker, her anxieties, her psychological comprehension and limitations, her personal biases and blind spots. It is within the totality of this field of interest that the practice of consultation must find its way.

The case-work supervisor meets the same kinds of problem, but with a much greater concern for relating her activity to the function of the agency, its place in the community, and its public or social responsibilities. The supervisory process, then, clears the way for the psychiatrist to give his undivided attention to the emergent stresses and conflicts in the worker-client relationship, and to the separate problems of client and worker. He focuses, however, on the specific problem of the worker; in a fundamental sense, therefore, his efforts are primarily worker-oriented, and secondarily client-oriented. Of the supervisor's activities, on the other hand, one may say that they are primarily agency-oriented, secondarily client-oriented, and finally worker-oriented.

The supervisor functions directly as a teacher in orienting the new or young worker to the requirements of the particular agency. As the worker acquires more experience in the agency, supervision becomes more a matter of the sharing of problems, and hierarchical differentiations should then tend to be minimized. If the supervisor has to continue to exercise authority, one would look for some failure in her supervisory practice, or some basic defects in the skills or capacities of the worker.

In psychiatric consultation, the emphasis should always be

on the sharing of problems. However, sharing by supervisor and worker goes on against the backdrop of a common professional experience, while worker and psychiatrist try to find common ground out of diverse professional backgrounds.

3. *The Contribution of the Psychiatric Consultant.*—I have suggested, in a previous discussion of this subject,¹ that the most significant contribution that the psychiatrist can make as consultant is to offer the worker a certain *quality of reassurance*. Whatever this quality may be, it contains at least the following elements: It allows the worker an opportunity for relief of the anxieties stimulated by the particular client; it accepts the validity of her skills and her efforts—i.e., respects her professional rôle and competence; and finally it maintains her sense of personal and professional integrity.

The psychiatrist's consultation is reassuring to workers because, after all, they do have to deal with a great many individuals who display severe personality disturbances, and an often alarming depth of psychopathology. The great majority of social-agency clients, in addition, live under conditions of economic privation and insecurity, which often make them inaccessible to direct psychiatric treatment. The presenting complaint is usually not psychological, but social, and, therefore, very properly lies within the province of the worker. On the other hand, psychological conflict is ever present, and while it does not interfere in every case, it is often a sufficiently powerful force to cause disquiet and unease in the worker who is conscientiously attempting to meet her client's needs.

Where the worker does not understand the psychological interplay in the client's personality, and particularly where it actively interferes, as it so often does, with the help that she can offer, then the worker must, in self-protection, harden herself, dull her perceptions, and blunt her sensitivities, or become the victim of a nagging flow of anxiety. If she can be assured, through psychiatric consultation, that she is not remiss in carrying out her responsibilities, if she can come to understand the client's motivations and the limitations of case-work or psychiatric help, then she can go on with her

¹ See "Psychiatric Consultation in Case Work Agencies," by Jules V. Coleman. *American Journal of Orthopsychiatry*, Vol. 17, pp. 533-39, July, 1947.

job in a clarified reality atmosphere. It is difficult for workers, or for any one else, recognizing how much is needed, to face a growing accumulation of fear of not doing as much as might be done. Reassured about what cannot be done, one may then often do a great deal more than might at first have seemed possible.

Whether the psychiatrist sees the client himself, should in general be his own responsibility to decide. If we think of consultation as worker-oriented, then the main emphasis would be on the help that can be offered the worker. It is advisable not to establish a routine of having the psychiatrist see every client for whom consultation is requested, since this would tend to establish a program of psychiatric service rather than one of psychiatric consultation, and this is justified in very few agencies. It is certainly inappropriate in a welfare or placement agency, where the social services themselves promise the most effective method of relieving client anxieties. And it is questionable whether any kind of social-work agency should or can organically incorporate a program of psychiatric-treatment service.

In a family agency, where the presenting request for help is often an emotional or interpersonal difficulty, rather than economic or social breakdown, the contribution of the psychiatric consultant may still follow the same pattern. Family agencies are extending their services into areas of problems that not very long ago were considered to be clearly the domain of psychiatry. That they are able to do so is a tribute to the effectiveness of the collaboration between dynamic psychiatry and social-work teaching and practice.

It must still be evident, however, that the social worker cannot be trained in psychopathology and psychodynamics and equally as well in social pathology and social process. Such a training program would probably require many more years of graduate instruction, and would still leave unsolved the problem of harmonizing the present-day social orientation of the social worker with the medico-biological, individualistic approach of the psychiatrist. It may be possible to create a new socio-psychologic discipline as a substitute for present-day social work, but if this were done, there would still be a need for a large corps of trained workers to meet the pressing demands of the victims of social disorganization, and this

still seems to be the major and inescapable responsibility of social work as a profession.

It seems to me that the problem in the family agency's direct work with the emotionally disturbed client must still be formulated in conceptual terms that are consistent with the developmental traditions of social work as a profession, and not in terms of the concepts of another discipline. In other words, it seems to me that, regardless of setting, social work in all its case-work practice must find a common denominator of psychological orientation, a framework of psychological concepts that is in keeping with its traditional rôle and the variety of professional activities for which it assumes responsibility.¹

4. *The Responsibilities of the Agency.*—What requirements should an agency set up for itself before it brings in a psychiatric consultant? The first and most important is that it must have enough trained workers to facilitate selection of cases for consultation and to permit the proper integration of the psychiatrist's contributions into everyday practice. It is important that the agency should know what its own responsibilities are, and should not expect the psychiatrist to act as a substitute for trained workers. It is particularly important that supervisory personnel be well-trained in order to minimize the possibilities of friction and rivalry.

It should be kept in mind that there are very few psychiatrists indeed who have any kind of training for the rôle of consultant. The graduate training programs in psychiatry give very little if any attention to this phase of psychiatric activity, even though it is actually rather widely practiced at the present time, and will probably be even more in demand as time goes on. This means in effect that the agency will usually have to provide its own training opportunities for psychiatrists whom they wish to employ as consultants. It is simply impossible for untrained workers to establish a thoughtful and meaningful learning experience for a psychiatrist inexperienced in this field.

It is conceivable that an agency with untrained workers may wish to use a psychiatrist for in-service training, but this is an unreasonable plan, since there is again nothing in

¹ See "Psychotherapeutic Principles in Casework Interviewing," by Jules V. Coleman. *American Journal of Psychiatry*, Vol. 108, pp. 298-302, October, 1951.

the training of the psychiatrist that could qualify him to teach others how to do social work. Furthermore, it is an extremely difficult matter for untrained workers outside of a school setting to incorporate into their thinking the complicated and subtle concepts and orientations of modern dynamic psychiatry. On the other hand, a large agency with an experienced group of trained supervisors, and at least a nucleus of trained workers, may find a psychiatrist a valuable ally and collaborator in carrying out an in-service training program.

In the matter of the selection of the psychiatrist, I do not believe that one should take the position that any is better than none. On the contrary, a psychiatrist who cannot adapt himself to the special demands of this kind of work experience is infinitely worse than none. It is not just a matter of training in dynamic psychiatry, particularly psychoanalysis, although this is essential. Nor is it just a matter of interest, although this, too, is essential. Of crucial importance is the psychiatrist's capacity to relate himself to the staff in a way that will provide a maximum of the *quality of reassurance* I have mentioned above, with a minimum need for the exercise of impulses of control and domination. This calls for a psychiatrist who can make his own professional contribution while according to his social-work colleagues a full measure of respect for their professional contribution and a full and rich appreciation of the meaningfulness and dignity of the professional status of social work.

On the other hand, I would like to stress that the contribution of the psychiatrist is not his responsibility alone, but also depends to a very considerable extent on how clearly and thoughtfully workers are able to formulate and present their problems for the psychiatrist's consideration. An extremely valuable aspect of consultation is that it provides the worker with a stimulating opportunity to rethink a particularly complicated client problem outside of the pressures of everyday routine.

I would not like to conclude these remarks without returning for a moment to a question that I raised, but did not fully explore earlier in this paper. I am referring to the educational function of the psychiatric consultant. The content of the psychiatrist's teaching is largely in the areas of psychodynamics, psychopathology, and the technical aspects

of treatment management. The psychiatrist is interested in evaluating personality and behavior, tracing patterns of disturbance, and clarifying the client's response to his life situation and particularly the client-worker relationship. However, he offers his observations and opinions not as a teacher to a student, but as a consultant to another professional worker. The source of his authority is in his knowledge and not in his relative status.

On the other hand, this is not entirely a consultant function because the psychiatrist also learns from the worker. He does so not only in order to do a better job in his work with the agency, but also for the enrichment of his own professional understanding. In the social-agency setting, then, the psychiatrist is more than an inside expert. He is also a participant in a process in which he has a vital professional stake. He engages himself in a two-way learning experience in order that the client may be better served.

In the last analysis, all our concerns and considerations are important only as they lead to improved service to clients. As consultant to a social agency, the psychiatrist has a unique opportunity to work professionally in the interests of a large number of distressed and harassed people who, with more than their share of personality disturbance, would not otherwise be able to find, or are not otherwise accessible to, psychological treatment. In his social-agency work, the psychiatrist has the opportunity to learn that treatment of emotional disturbance is not the exclusive domain of psychiatry, but is a general social function in which many kinds of agencies—and, for that matter, many kinds of social institutions—participate.

To summarize briefly, I have discussed the work of the psychiatrist in a social agency in its consultative, educational, and participant aspects. I have considered the separate responsibilities of psychiatrist and agency in creating those optimum conditions of collaboration that best serve the psychiatrist-worker relationship and, as a result, the worker-client relationship. The psychiatrist may offer the worker reassurance and support, and may share with her his understanding of the client's behavior. The psychiatrist has the opportunity to learn something of the integrative or destructive effects of social forces on personality. He may learn

to appreciate the creative potentials of personality integration in the face of severe economic and social stress.

In their work together, psychiatrists and social workers have demonstrated the rich possibilities for the extension of dynamic insights to many hitherto unattainable therapeutic objectives.

LIFE IS THERAPEUTIC

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PROFESSIONAL people have long looked upon it as virtually axiomatic that mental breakdown occurs in crisis situations, that long dormant neuroses and psychoses come to dominate an individual as a result of some life crisis. In other words, life itself has come to be regarded as a causative factor in mental breakdown. The impact upon a poorly integrated personality of an unforeseen or unexpectedly difficult life situation results in certain collapses within that personality.

What we have lost sight of is that life is also therapeutic. Given the proper life situations, many of these disintegrating personalities reintegrate themselves. This is recognized even in our folk knowledge. Epigrams concerning it can be traced as far back as Hippocrates' pronouncement, "Healing is a matter of time," and Terence's, "Time assuages sorrow."

The common people have always recognized that one of the best treatments for soreness of the spirit, for disintegration brought on by crisis, is simply to let life run its course. In time the stricken personality will reintegrate itself as a more normal routine establishes itself.

Of course this may have been an easier matter in a simpler culture, where primary groups adjusted themselves as much to the stricken soul as the latter made adjustments it did not fully comprehend. But the principle remains true even in our more complex modern culture.

Every college counselor is aware of the fact that mental breakdowns increase during examination periods. Yet many of these same personalities that seem incapable of meeting the crisis of an examination, later, when given the responsibilities and recognition usually accorded the college graduate, reintegrate themselves and become wholesome, well-rounded personalities. Many neurotic tendencies that have persisted over a period of years, reaching their climaxes in the crises of adolescence and youth, disappear in the later years of com-

munity recognition. Quite often marriage and the emotional satisfaction it brings (response and emotional security—the feeling that one does mean something to some one else) are sufficient to bring an end to the neurotic trend. Douglas Campbell, the psychiatrist, once wrote that a certain patient had at last "accepted life."¹ The particular incident prompting this remark was the birth of a son to this patient and her husband.

In a recent study of juvenile delinquency,² Austin L. Porterfield, after finding that the college student has just as much of a tendency toward delinquency as the child of the slums—though he is less often charged with his offenses—wrote:

"The association of the college student has been distinguished from that of the court cases as much by having a wider and more versatile range as by anything else. His participation in group life has not been limited to a group and cultural level so low and impoverished as that of the less fortunate child. . . . [When he] graduates from high school, he goes to college. In college he feels that 'he has a future,' that his life will unfold in a socially respected, if not always uprightly conducted, vocation and a home of his own. He will have status in the community, and the range of his social participation will grow."

In other words, delinquency is a common trait of all adolescents. The child, however, who grows into a man with responsibilities and status in the community sloughs off these tendencies. Life itself has furnished the needed therapy.

Time after time I observed this in the army. Some soldier who had received no military recognition (more often than not he had been more fortunate in his pre-army status) turned in upon himself and reached a state in which he was unfit for duty—even to the point of psychosis. This same man, given a job that implied recognition and which he could handle to his own satisfaction, found himself forgetting all about the things on which he had previously brooded. A life situation had intervened to pull him out of the mental slump into which he had permitted himself to fall.

One such situation in particular occurs to me. The man was on his way to an overseas theater. His company commander asked me to speak to him, saying that he had been

¹ A personal communication.

² "Delinquency and Its Outcome in Court and College," by Austin L. Porterfield. *American Journal of Sociology*, Vol. 49, pp. 199-208, November, 1943.

brooding about something. I found that the man was thoroughly discouraged. He had a wife and three children at home. He couldn't see how they could possibly live on the allotment the government gave and what he could spare out of his own pay, a total of about \$125 a month. He had been earning twice that before coming into the army. He just couldn't see how the family could survive. He said nothing about suicide, but several things in his speech led me to believe he was contemplating such an act as a means of furnishing them with some extra money.

Further discussion revealed, too, that he had been in the army less than three months and felt that he was being treated very unfairly to be sent out so soon, when so many others who had been on duty for several years were permitted to remain behind. He was thoroughly convinced that he would not return home alive. The government was sending him out to virtual death. (He was an infantryman and had evidently heard how badly some infantry units had fared, although he was apparently not aware of how few units actually see heavy action.) In other words, he could see no light at all in the picture and no amount of reasoning could raise the pall that hung over his thoughts.

I told the company commander that it might be wise to watch him lest he do something drastic and the company commander agreed. The next day, however, he made the man acting squad leader. Within a few days one could almost see his shoulders lift and a new light come into his eye. He took his responsibilities seriously and soon his worries had left him almost completely. A new life situation, with recognition and responsibility, had ended a very dangerous trend.

Another case comes to mind of a college student who was abnormally introspective. He felt that every one about him was making fun of him, although he was almost universally respected for his brilliant mind and pleasant disposition. He feared to become intimate with any woman for fear she would take advantage of him and ridicule him. One woman virtually threw herself at him physically, and in spite of his awareness of what was happening, he pretended not to know what was going on for fear she would later spread stories of how he had tried to seduce her. His fear of women was such that he

frequently masturbated before a date. This, of course, made him feel secure. His sexual need was not so great but what he could hold the woman at a safe distance.

Upon graduating from college, he received a very desirable teaching job, one that all of his fellow classmates had sought. It turned out to be one with a good deal of status that demanded administrative abilities of a high order. He found himself in constant contact with the public and intimate contact with various individuals. He found that they were coming to him for what he had to offer. Before he was aware of it, he had lost all his self-consciousness in public. He was so busy that he had no time to worry about what others thought of him. And to his surprise, he found that they all thought highly of him. Even his relations with women became more normal and a happy marriage resulted. An excessive introversion was transformed by a life situation into a very wholesome extroversion.

Still another case illustrates this process very aptly. A young man with quite effeminate characteristics was working in a stone quarry. Stone-cutters are a pretty rough-and-ready lot and they made life miserable for him. He was called "Gertrude" to his face. He knew that they were ridiculing him and were referring to him as a homosexual. As a matter of fact, he had had no homosexual experiences and had not thought of having any—although this does not preclude the possibility that had he been exposed to the proper situation, he would not have quickly become a homosexual. Certainly his inclination to lay his hand upon the arm or shoulder of any one with whom he talked would indicate such a tendency.

At any rate, he came to me broken-hearted. What could be done to gain the respect of the men with whom he worked? I told him I thought that there was no chance of his doing that. We surveyed his handicaps and advantages and came to the conclusion that he had better secure the type of job in which he could work pretty much to himself and not be constantly thrown with the "he-man" type of work gang.

His face brightened as he said, "I've sometimes thought of becoming a watch-maker."

"Capital," I answered. "You should begin looking about for some means of getting the proper training and apprenticeship."

Although he remained on the quarry job for some weeks after that, he straightened up and was able to meet most of his fellow workers man to man, for he was now on the road to a job in which he wouldn't have to worry about their attitude toward him. His spare time was spent in correspondence and interviews as he sought to establish the proper connections to enable him to become a watch-maker. The possibility of recognition in a field in which dexterity counted for far more than crude strength had enabled him to surmount a crisis that might well have been a breaking point for him.

My contention is this: Any mild personality problem will disappear if the individual is put in a situation in which he receives some recognition. Our job is, therefore, to help our clients to a reorientation that will enable them to place themselves in a situation in which some degree of recognition is possible for them. Of course, this is not always feasible, but as the work of our clinics receives wider recognition, as personal counseling becomes more or less matter of course, we may be able to help these individuals into situations in which the desired recognition can be obtained.

Many devices can contribute to this. One of the most helpful is the use of vocational-aptitude tests. Confronted with such a frustrated personality, if we can quickly determine his vocational aptitudes, we will be in a much better position to help him into a field in which recognition will be most likely to follow.

Placement is an important adjunct to this process. If those who are doing personal counseling were in a position to make recommendations to employment or personnel bureaus, this would expedite the matter greatly. In a few cases I found sympathetic personnel officers in army organizations who were willing to assist me in such reassessments of frustrated men. The army, however, is such a vast and impersonal organization that we were not always able to achieve the desired results in such placement.

Education is another important adjunct. If funds are available for the specialized training of those individuals who definitely cannot fit into a run-of-the-mill situation, we are well on our way to solving some of these problems. Here, too, educators and counselors will have to learn to work together.

One last word as a sort of appendix should follow: Many a

personality problem results from poor administration. I have in mind one army company that came to my attention. About half of my personality problems came from this one company. Home situations were driving the men frantic; they had not been given a square deal in the army, etc., etc. Many of them even came up for neuropsychiatric examination.

Suddenly the number of men from this particular company coming to me and the medical officer dropped to less than half its previous average. We immediately inquired as to the reason. A new company commander had taken over and completely revamped the company. Non-coms who had been bullying their men were put in their place. Skilled workmen who had received no recognition were put in jobs for which they were fitted. Instead of being suspicious of his men and constantly criticizing them, this young company commander identified himself so completely with them that he was actually taking their point of view to higher echelons, even when this point of view was obviously prejudiced and partisan. The result was that the men worked together in greater harmony. There was less personal friction within the organization, and family and personality problems tended to take their properly subordinate place.

In all likelihood, a change of administration in many of our business establishments would reduce the number of personality problems. A man happy in his job is less likely to brood over his problems than one who feels frustrated on his job.

Essentially our task, in most cases of minor personality problems, is to try to establish them in an environment in which the problems will assume their proper proportions. We must let nature take her course, but seek to coöperate with her as much as possible. Time is therapeutic. Time *does* heal. But we have to give time the best circumstances under which to work. Otherwise time may actually deepen the crisis instead of alleviating it.

As Hippocrates said, "Healing is a matter of time, but it is sometimes also a matter of opportunity."

A GUIDE TO A COMMUNITY COMMITTEE ON THE MENTAL HEALTH OF THE AGED

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A GREAT amount of interest, time, expenditures, research, and clinical talent in the mental-health field has been devoted to the mental health of children and young adults. Behind this focus there is the assumption, supported by the experience of physicians, educators, social workers, clergymen, and others, that "as the twig is bent, the tree's inclined."

But there are tremendous twists that affect people far past the sapling stage. We know that people have their psychological storms that twist and break them later in life, whereas the twig can more easily spring back. The old trunk is more rigid. Changes occur in the bodies of old people that make it necessary to deal as carefully with them as the pediatrician has to deal with the child. Strong emotion is apt to impair clear thinking in the most vigorous of us, but ridicule, callous handling, punishment, in the case of an oldster, may destroy his thin and shaky balance and throw him into an isolation that does not tend to heal itself. Still, we know that mental impairment is not an inevitable result of aging and that the greater freedom that often comes only in later years may be the open sesame to genius and fame, as with Grandma Moses.

An important part of the program of every mental-health association—on the national, state, and local levels—should be a concern for the mental health of old people. The details of general organization of a local mental-health organization, including principles that are helpful to its committees, will be found in the pamphlets, *Manual for Organizing State and Local Mental Hygiene Societies*, and *Evaluation of Community Needs and Resources for Mental Health*, by Marian McBee and Marjorie Frank.¹

¹ Both pamphlets can be obtained from The National Association for Mental Health, 1790 Broadway, New York 19, N. Y., the first at 50 cents a copy, the second at 25 cents.

Local mental-health associations have access to the resources of the state association for mental health as well as those of the national headquarters of The National Association for Mental Health, directly or through the state association, to help them with all aspects of their work, including their committees.

The Committee on Mental Health of the Aged.—The size of the local committee on the mental health of older people is not too important. It is more important that it be composed of interested or potentially interested, vigorous, active members. Should the committee find itself with many members, perhaps more than ten, it can divide its work. It can make the task of each member easier by assigning different phases of its work to subcommittees, such as subcommittees on the mental health of old persons at home, in the hospital, and in special homes. Whatever the method of appointing the chairman of the committee, it is good sense to have the committee itself, except for its first chairman, express its opinion as to potential chairmen, since it soon becomes the best judge of promising leadership. Inactivity is one of the most serious threats to the effectiveness of committee work, and all committees should guard against drifting into inactivity, as a holiday, a storm, or the absence of the chairman may interfere with the holding of a meeting. A regular meeting time is one excellent safeguard and no meeting should adjourn without having a clear decision as to the time of the next one.

Developing the members of the committee is fundamental. It must be assumed, whether or not it be true, that most of the members of such a committee will have had little experience in this field, and that the first task of the committee will be to increase its own understanding. To this end it should study selected literature, such as pamphlets and books that interpret the mental-health problems of older people and point out what may be done for them. The following list of readings is suggested, with information as to where the material may be obtained:

SUGGESTED READINGS

Constructive Programs for the Mental Health of the Elderly, by Frederick D. Zeman, (Reprint from MENTAL HYGIENE, Vol. 35, pp. 221-34, April, 1951.) National Association for Mental Health, 10¢.

Community Action for the Aging. New York State Association of Councils of Social Agencies, 105 East 22nd Street, New York 10, N. Y. 20¢.

Recent Trends in Mental Hospital Care, by Albert Deutsch. National Association for Mental Health. 5¢.

On the Positive Side. (Published by the American Psychiatric Association Mental Hospital Service.) National Association for Mental Health. 50¢.

Education for a Long, Useful Life, by Homer Kempfer. (Bulletin 1950, No. 6, Federal Security Agency, Office of Education.) U. S. Government Printing Office, Washington 5, D. C. 20¢.

Mental Health Needs of the Aged, by Robert H. Felix. (Reprint from the General Federation Clubwoman, Vol. 31, pp. 11-12, 22, March, 1951.) Federal Security Agency, Public Health Service, National Institute of Mental Health, Bethesda 14, Md. Free.

The Problem of the Aged Patient in the Public Psychiatric Hospital. Group for the Advancement of Psychiatry, 3617 West Sixth Street, Topeka, Kansas. Report No. 14, August, 1950. 10¢.

Mental Health Programs of the 48 States. Council of State Governments, 1313 East 60th Street, Chicago 37, Ill. \$4.00.

Happiness in Old Age, by George Lawton, (Reprint from MENTAL HYGIENE, Vol. 27, pp. 231-37, April, 1943.) National Association for Mental Health. 10¢.

Recreation and Mental Health, by William C. Menninger. (Reprint from Recreation, Vol. 42, pp. 340-6, November, 1948.) National Recreation Association, 315 Fourth Ave., New York 10, N. Y. 10¢.

The Golden Age. New York State Department of Mental Hygiene, Albany, N. Y., 1949. 5¢.

When You Grow Older, by George Lawton and Maxwell S. Stewart. (Public Affairs Pamphlet No. 131.) National Association for Mental Health. 20¢.

Aging. Office of Publications and Reports, Federal Security Agency, Washington 25, D. C. Free.

Each member of the committee may be assigned a publication to study and report on. New publications will, of course, appear from time to time and information as to these will often be brought to the attention of the local association by the state association or the headquarters of The National Association for Mental Health.

Discussion of literature reports may be the subject of the initial meetings. These reports and other pertinent material should become a part of a file of the committee and be helpful in orienting new members who are added to the committee after it has got into swing. Such new members can also be helped by reading the more important articles themselves and discussing these with individual members of the committee.

An example of such a report follows. The points italicized

high-light the mental-health elements in their larger context and indicate matters of special interest to a community committee. The title of this report—*Findings and Recommendations of the New York State Joint Legislative Committee on Problems of the Aging*—is a good indication of its content. This is the third report of the Joint Legislative Committee on Problems of the Aging. The first, *Birthdays Do Not Count*, deals with the medical and economic problems of the aging; the second, *Never Too Old*, with employment conditions. The content of this third report is stated by the introduction as follows:

“ . . . society shuts the older person out of productive, useful life. Somehow, in our national race for expansion and wealth, we have overlooked not only some fundamental human values, but also some productive values. For with all the tremendous talent and energy that bless our wonderful American youngsters, we can ill afford, in terms of dollars and cents, to lose the ‘know-how’ and productive power of our 45-plus, 55-plus, and 65-plus groups. ”

“ But when millions of older persons face the slow death of forced retirement, when millions of persons face the hidden disaster of old age and relief rolls, *when thousands of oldsters are thrust into mental hospitals although all they need is love and understanding*, when millions of oldsters are consigned to a lonely old age, we move at a painfully slow rate. we in our neighborhoods, our communities, states, and nation have the wealth, the energy, the technical skill to see to it that our older persons have a chance to make their later years happy years. Industry itself, confused as it is about its relationship to the elderly, arbitrarily banning the hiring of older persons, spends nearly a billion dollars a year for pensions, and grants generous privileges to its senior workers. ”

“ If you work in a plant that has a compulsory retirement system, . . . it is sheer folly to do nothing to prepare yourself for the day when you will be retired. . . . Of course, coöperative action will be needed when individuals cannot cope with their own problems. That is why social agencies, medical groups, and government need to wake up to the growing challenge that already confronts us.”

The report specifies twelve areas of neglect of the aged as follows:

1. Inadequate social-security payments.
2. Lack of study of ways of preventing old-age dependence.
3. *Improper placement of oldsters in state hospitals.*
4. *Unnecessary retirement at sixty-five.*
5. Refusal to hire men over forty-five and women over thirty-five.
6. Forced retirement.
7. Barring old people from housing projects.
8. *Ignoring the recreational needs of old people.*
9. Inadequate treatment for the chronically ill.

10. Inadequate supervision of homes for the aged to prevent abuses.
11. Bad county homes.
12. Ignoring the psychological needs of the aged.

The report then goes on to point out that we allow these abuses to take place because the public has not demanded better services for the aged. The committee has concentrated its attention on the following six areas:

1. Employment problems of the elderly.
2. Health needs.
3. Recreational needs.
4. Integration of state⁸ programs.
5. Community services.
6. Development of informed medical, industrial, social-work, and religious leaders.

In its work, the committee has been guided by five principles for dealing with oldsters:

1. Activity is a biological need.
2. Oldsters must feel useful and wanted.
3. Aging is a personal and local matter.
4. Many approaches need to be encouraged.
5. Preparation for old age should begin early.

The committee has cast about for concrete instances of activities that have been tried enough to be given serious consideration by any community. It senses some new trends as follows:

1. Old people are being viewed as a national resource.
2. Medical discoveries with regard to the diseases of old age are being made.
3. There is more serious attention to the quality of homes and nursing homes.
4. A national committee on aging is being planned.
5. Professional education in health and welfare, including the needs of the aged, is improving.
6. Economic security for the aged is being pressed.

The committee then spells out the financial stake of New York State in the problem of the aged and the state activities in their behalf as follows:

The state education department provides vocational rehabilitation and promotes courses for older people.

The insurance department supervises pension and retirement funds.

The welfare department develops and explores standards for nursing and old-age homes, supervises old-age grants, receives appeals on grants.

The labor department maintains a file of successful jobs for the old; job placement.

The department of mental hygiene develops cottage-care, foster-home, and family-care services for the old in mental hospitals.

The housing department provides housing.

The health department focuses on old age.

The state provides a retirement fund for state employees.

The banking department supervises bank savings as trustees of pension funds.

The report outlines the components of community programs for the aged as follows:

1. Permanent job finding.
2. Research.
3. Services for the chronically ill—home care, housekeeping, clinical services.
4. *Improvement of nursing homes and old-age homes.*
5. Educational opportunities.
6. Geriatric programs in the health department.
7. Citizen coördinating groups.
8. Community education.
9. Financial counsel.
10. *Mental-health programs.*

The report mentions also state, local, and federal coöperation. The last three-quarters of the report is devoted to details of these categories of work.

Acquaintance with the literature, as exemplified by this report, is important also in helping the community committee to decide what it may recommend for general use with the public. And it will be helped not only in its study of the community, but in formulating its recommendations and in placing them in some order of importance. The various publications will also identify the authorities in the field upon whom the committee may call for advice in making decisions that require technical knowledge. Its study of the community will also reveal persons with special competence in this area who may be residing in its territory.

A Few Facts.—From such reading, the committee will learn that about a third of those admitted to mental hospitals are diagnosed as having one or another of two common mental disorders resulting from old age—senile dementia, diffuse deterioration; or psychosis with arteriosclerosis. Some patients have these disorders in very mild form, such as mild

impairment of memory. But it may be necessary for them to be in our mental hospitals because the crowding and hazards of home life make it hard, if not impossible, to care for them under modern conditions. For example, they may be left alone during the day because every one is away at work, or they may sleep poorly at night and keep the family awake. They may turn on the gas and forget it.

Old persons of this type can be cared for better by some other arrangement than a mental hospital, but most communities to-day have no alternative. We do not know what percentage of the patients in our mental hospitals need not have been placed there, because there is no case study to tell us. There is no firm agreement among authorities as to the kind of home in which these non-psychotic old people should live, whether foster homes, segregated cottage communities, or congregate institutions. While one-third of the patients admitted to the hospitals have mental disorders due to old age, the life expectancy of these patients is very short and nearly all of them die within a year's time. For that reason they do not accumulate and make up a high percentage of the population of the hospitals. They amount to about 12 per cent of the total. Some have suggested separate hospitals "for old patients, but the concentration of such patients in one location would take them further from their communities and make it hard to get competent staff.

While much of the discussion is focused upon removing the aged from our state hospitals, there is a tendency to ignore the possibility that some who are not in these hospitals may really belong there. Many of these old people are outside their own homes in nursing homes or in hospitals for chronic illness, which lack the staff and facilities to care for psychiatric problems. Psychiatric consultants for such homes and hospitals may be an adequate solution for some of these problems. Other cases may need to be hospitalized in a mental hospital.

But mental illness among old people is only a small part of their total mental-health problem. Like the rest of us, old people are mentally healthier when they employ their talents and contribute to their own support. Hardly a day passes but that each of us is confronted with mental-health problems of people who are growing old. They have anxieties about

making ends meet, about the narrowing circle of contemporary friends, about retirement and their inability to maintain the pace of earlier years. There are the little notes that the aged write to themselves as safeguards against declining memory, usually to be forgotten either because there is no memory impairment, but only fear of it, and notes are unnecessary, or because memory has declined so far that the notes also are forgotten. These are all mental-health problems, some more thoroughly so than others. Gross loss of memory may be undisturbing, but the twilight of faded memory produces confusions of people, time, and incidents that result at times in weird delusions.

Some of these patients are confused as a result of their poor memory because the memory of old people tends to weaken first for recent events. It is, therefore, helpful and less confusing to them if they can be kept in their old haunts and with familiar faces, instead of being placed among entirely new people in new places.

These problems of old people can be softened if understanding citizens will study them and give of their time, along with other citizens, in a joint effort to solve them. In this way the impotence of the citizen working alone may be replaced by the strength that comes from being a part of an organization with a focus, such as a mental-health association.

What Is the Community Doing?—The next step for the committee is to learn what is being done for or to the mental health of old people in its community. To get a full perspective on the mental-health problems of older people in the community, the committee should to a certain degree be acquainted with all of the community activities that have to do with old people, such as recreational and other group activities. This will provide the framework within which the mental-health aspects may be studied. There may be other active study committees of the local association, and care should be taken that there is no duplication—rather a joining of forces to obtain needed facts relating to the various committees.

The committee should also not limit itself to its own community, but see what is going on in other accessible communities and in agencies under state and national auspices.

This should be done through or in coördination with the state mental-health association, to avoid duplication.

As in the case of reading, studies of the needs and resources can be made by having one or two members of the committee cover each activity and report on it. From these individual studies, certain activities will stand out as being so significant that the whole committee may wish to find out more about them.

The first task of the committee is to find out where to look for these activities. There are a number of community agencies that can tell where things are going on that will be of concern to it. The list given in *Evaluation of Community Resources for Mental Health*, previously referred to, will be of help here. These agencies will not be found in every community, nor is the list itself complete. However, by assigning one or more of these contacts to each member of the committee, just as was done with the literature, a surprising amount of work can be done. A list of visits and studies can be developed and the reports on these will constitute an important foundation for the committee's work. The plans for visits should, however, be cleared with the board in order that representatives of several committees may work together in visiting any one place.

An example of a report to the board of directors of a local mental-health association of a field visit by a committee on mental health of the aged is the following:

"It was a lovely day in late October when the Committee, accompanied by a social worker, visited the Colony for the Aged.

"A cluster of small cottages, filled with busy, happy, independent old people, watched over by a warm-hearted, competent woman, able to guide them, yet let them alone—that is the Colony, incorporated in 1937. It is well worth a visit and any one who goes will receive a warm welcome at the Community House. This plan for providing independence with security, privacy with companionship, good living on a small income, is unique. The Colony is the life work of an unusually fine person. Devoted, enthusiastic, yet practical, the idea was hers. Its accomplishment is due to her and her board of control. No public funds, no profits are involved. There is no regimentation, but guidance and help are there if needed.

"With the founder giving the first 'push,' thirteen tiny cottages and a Community House were built by W.P.A. Each has city water, sewer connections, gas, and electricity, and is insulated. Each has a third of an acre of land. At first the rent was \$8.00, to-day it is \$10.00, a month and the number of cottages has grown to 29, some larger, many owned by

those who could afford to build them. These will belong to the Colony eventually.

"Located in sandy, pine-covered country, dry and mild, with only a step from house to yard, health is easy to maintain. Many people were gardening. One man's yard was filled to the brim with pansy plants and it was evident that he had given many to his neighbors. Self-help and good-will seemed to be productive of mental health, too. Every one we met was smiling, interested, cheerful. 'They are seldom sick,' we were told. 'If they are seriously ill, there is a hospital nearby. But generally the need to look after themselves is a powerful stimulant.' We were told of one man, whose wife had died recently, who was still able to go along although crippled with arthritis. A neighbor looked in every morning.

"One of our Committee, familiar with work in this field, was deeply impressed. She felt that such a plan might be a possibility for our county. Planning for the old is becoming more urgent with every year. At the recent National Conference on Aging, it was stated that New Hampshire in 1948 had the highest percentage of people over 65, 10 in every hundred. New Jersey was not far behind with 7.3 per hundred.

"Out of the eleven million people in the United States aged 65 or over, 3½ million had no money income of their own. Seven and one-half million had some, but for many it was less than \$500 a year. It is for people like these that the Colony was established. Over the fireplace in the Community House is this inscription: 'Dedicated to those in the twilight of life who seek Peace, Harmony, Contentment.' "

This colony plan is on the fringe rather than the center of a mental-health program, yet it is important as reflecting a service the absence of which often leaves the state hospital as the only recourse for dealing with adjustment problems of the elderly.

From contacts with various agencies in their community and from their general knowledge, the committee will be able to discover what is being done or should be done by the churches for old people. It will find the social agencies that are confronted with the problems of older people; the mental hospitals to which residents of the community would go when mentally ill; industries that may be confronted with problems of retirement; agencies that may give retirement counsel and assistance or vocational help; general hospitals; public-health agencies; and nursing homes. A report of the problems found in one community is given below. This is an initial report and, therefore, incomplete as an assessment of the community:

"1. The superintendent of our state hospital reports that old patients with limited memory defects are being sent to his hospital because a more appropriate agency does not exist in our community.

"2. There is a shortage of boarding homes and nursing homes for mildly affected old people.

"3. There is a lack of recreational opportunity for the old people of our community.

"4. Housing and other changes in families make it difficult for the hospitals to return to the community those old people whom it has been successful in restoring to fitness for community life.

"5. There is a lack of general public understanding of the mental-health problems of old people.

"6. The mental hospital lacks sufficient social-service staff to give the follow-up assistance that old people need after leaving the hospital.

"This is only a partial statement of the findings of your committee on mental health and old age. Further reports and recommendations will follow."

Planning.--In the course of their community survey, the Committee on Old Age will find out who in the community are carrying responsibility or exercising authority with respect to the mental health of old age. These authorities may have dreams that they have not been able to bring to fruition and frustrations that need to be overcome which the committee should know about. These people can do more in one visit to help the committee clarify the mental-health problems of the aged, and to plan what can be done about them, than the committee alone could accomplish in many months.

The committee will need to come to some appreciation of the relative urgency of certain problems and to make a selection for its initial attention. It should be in a position to present a report to the general board of the local mental-health organization. This report should cover the broader scope, the specific mental-health problems and needs of the aged, the areas chosen for initial attention, and the recommendations for action. The recommendations should be very specific as to *what* things need to be done, *by whom* they should be done, *when* they should be done, and *how* they should be done—that is, as to the plan of action. It should clarify the points at which its work impinges on that of other committees in the organization and it should, if possible, have made contact with these other committees for joint consideration of the areas that overlap. Also, in its plan it should point out how administrative committees of the organization, such as those concerned with legislation and public education, may be of help. It is, however, the task of the board

of the association, or other body to which it is reporting, to look for unseen areas of overlap and for statements not adequately supported by authority and fact.

The following are examples of recommendations:

"The committee recommends the following: (1) There is need for education of the community with respect to the needs of old people and conditions affecting them—such things as what families need to know and how to prepare for old age. It is recommended that this education be carried out through the same media as are used by the association for education with respect to other age groups, through public meetings, through securing of published materials from national organizations, and through the activities of the public education committee in getting organized groups such as service clubs and churches to include mental health in their regular programs.

"2. It is recommended that the county medical society be urged to prepare and distribute on request a leaflet which would help aged persons to find aid in meeting their medical needs, and that the chairman of the committee on old age carry this responsibility.

"3. It is recommended that the local social-service agency provide counseling service to old people who are considering entering homes, in order that they may make a choice in keeping with their individual mental state and needs, and that they be asked to establish housekeeping service for elderly persons in their own homes. It is suggested that this be accomplished through discussions between the executive of the local social-welfare agency and either a committee on old age of the mental-health association or another committee that can undertake the project.

"4. It is recommended that the committee on volunteers develop a volunteer service to old people in their own homes, possibly under church auspices, and that they be given special preparation for dealing with those having mild mental deviation.

"5. It is recommended that the association give its support to the Salvation Army's program for elderly women, providing for education, worship, fellowship, recreation, and service, and that it urge the extension of these services to other communities in the county and also to elderly men."

Getting Into Action.—Sometimes a recommendation calls for little further action by the committee itself, but rather for action by the legislative, by other committees, or through public education. Before action is begun, the committee should have its recommendations accepted and, if it is to participate in the action, should be given authority to proceed. From time to time the committee should report back to the hospital field-study committee of the board of the association and also should bring in additional recommendations for consideration. It should work closely with other committees that

may be carrying out its recommendations and make its members available to such committees as those on public education and legislation, which may have the know-how of their work, but not the specific information about the mental-health problems of old age. The board will set up a committee to carry out accepted recommendations.

It will soon become evident to any such committee that it is faced with a long-time, continuing task, and as it carries out this task, it will develop an understanding that will enable it to provide exceptional leadership in its community.

THE CHAPLAIN AS A MEMBER OF THE DIAGNOSTIC CLINICAL TEAM

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ACH of the well-established professional disciplines accepted to-day as an essential member of the clinical team has had its unique struggle in attempting to establish the particular contribution it has to make in the total diagnosis and treatment of the emotionally disturbed person. I refer, of course, to clinical psychology, psychiatric social work, and psychiatry. Even to-day, however, these disciplines, which we who are intimately involved in this work consider essential to an adequate and complete clinical evaluation, are not everywhere accepted to this same degree. Now another profession, the ministry, which is also concerned with the adjustment of people, both emotional and social, has begun to extend its interests and contributions beyond the long-established traditional rôle into clinical field work.

In 1925, a new program of training Protestant clergymen for work in hospitals and correctional institutions was begun by Dr. Anton T. Boison at the Worcester State Hospital, Worcester, Massachusetts. To-day there are probably few, if any, state mental hospitals, general hospitals, training schools, or prisons that do not have full-time or consultant chaplains on their staffs. The Council for Clinical Training, Inc., under the direction of the Reverend Mr. Frederick C. Kuether, is to-day a well-integrated organization, established to provide Protestant ministers with clinical training for more inclusive parish and institution practice.

For many years the Roman Catholic Church has had among its religious Orders the Viatorian Community, whose primary function is to train priests for educational and medical institution work.

The rôle of the religious leader in the clinical setting as pastor and religious counselor has become well-established and much has been written on the various aspects of such

work. Therefore, this paper will not discuss in any detail this phase of the chaplain's work within the clinical institution. The particular phase that will be discussed is one unique in the chaplain's work within this setting and concerns the chaplain as a member of the diagnostic clinical team.

Early in 1949, under the present administration at the Illinois State Training School for Boys, the division of religious services was integrated as an equal member into the clinic team. Two full-time chaplains, one a Protestant minister and the other a Catholic priest, comprised this division. A Jewish rabbi served in a consultant capacity. It was the opinion of the administrative and clinical staffs that the addition of the religious leader's contributions to the diagnostic study of the delinquent child would provide more complete understanding of each case than that obtained by means of the traditional diagnostic procedure. Prior to the above date, the school chaplains occasionally sat in at staff meetings and rendered their opinions concerning certain boys, but not as regular clinic-team participants.

It was fully realized by the staff members that this move was novel and experimental. They also recognized that the future success of this action depended largely upon the fact that it was not an innovation initiated by the administration and forced upon the regular clinic members, but that prior to these changes the plan was fully discussed, both as to its advantages and disadvantages, by all key clinic and administrative personnel and was unanimously agreed upon before being instituted. Actually, practically the only scepticism as to the value of the chaplain in this rôle came from the chaplains themselves. Their anxieties centered around the question of how they would fit in with the other members, to what degree their findings and opinions would be accepted, and how best to organize their interview so that it would be of the most clinical value.

The administrative and clinical staffs were also fully aware that these additional members of the clinic team could not be just any graduate theologians who had had clinical training, but that they required, in addition to specialized training and experience, certain personality characteristics that would qualify them for this type of relationship, the most important of which is intuitive understanding of the needs of emotionally

maladjusted children. The Illinois Training School for Boys was fortunate in having two resident chaplains with the desired extensive clinical training and experience together with the necessary personality characteristics. For this reason, the staff felt encouraged in undertaking the new venture.

This enlarged clinical team, composed of representatives of four disciplines instead of the usual three, has now been functioning for over three years. The arrangement has been completely accepted by every one, and the staff would be very reluctant to go back to the former, less inclusive team, for these men have increased significantly the total understanding of individual case dynamics and personality structure. Also, there has occurred a cementing of professional relationships between the ministerial and psychiatric disciplines ordinarily not thought possible or even advisable.

Certain questions have no doubt arisen in the reader's mind as to how the chaplain functions in this new capacity.

What does the chaplain's interview consist of that makes it different from that of the other members of the diagnostic team?

What information is revealed in this examination that gives it unique contributing qualities?

To what extent does this interview duplicate or conflict with the social worker's or the psychiatrist's examination?

How much religion is involved in the interview and in what way?

These are a few of the questions that present themselves and they can best be answered by a discussion of the function of the chaplain in this new rôle, together with a brief report of abstracts from three cases which illustrate how certain psychodynamics and psychopathology are often brought to light by the information obtained, which frequently confirm or refute questions raised by other examinations.

During the intake period, the chaplain, like the other workers, has a regularly scheduled time for interviewing a new boy. Following the completion of the interview, the chaplain writes up a report comprising his significant findings and resultant opinions for presentation at the diagnostic and treatment staff which takes place during the third or fourth week after a boy's admission to the institution.

Among the areas investigated during the interview are:

1. Personal religious history, including education, church attendance, religious attitudes, and religious conceptions, which includes frequentation of the sacraments by the boys of Catholic faith.

A common inquiry concerns the boy's spontaneous and immediate recollections of religious historical stories and events, which have often revealed evidence of some very interesting emotional conflicts, material similar in value to the early memories recalled in the psychiatrist's examination.

2. Family religious history, including church attendance and interest, and determination as to whether religious interest is of a healthy or a pathological character.

3. Reactions of the boy during interview, including general appearance, reactions to chaplain, reactions and attitude to the discussion of parents, and reactions to the discussion of sexual material with a chaplain.

4. The chaplain's impressions, including such considerations as degree of conscience formation and patient's ability to utilize this mental function; character development as revealed in patient's manner and degree of religious integration into his daily life; general ego strength in relation to the possibilities for treatment; and type and degree of treatment indicated.

At the diagnostic staffing, the chaplain presents his report and renders his recommendations along with the other team members, and then enters into the discussion of all plans formulated in each individual case.

To illustrate how the information obtained in the chaplain's interview has been helpful, I cite extracts from three cases:

1. John S., when asked to recall a story from religious history, could offer only the incident of the hair-cutting scene from the tale of Samson and Delilah, but this he remembered in detail. It was noted that in relating the anecdote, he manifested more overt anxiety than usual. Examinations by the other clinic disciplines revealed that the youth had severe castration fears which were related to his early-life relationship with a strict, punitive mother and a weak, passive, submissive father.

2. Another child, Billy R., recalled most vividly the story of David and Goliath, and as he was relating the incident it was observed that he identified strongly with David. When this clue was investigated further and later discussed with the other clinical staff members, there was revealed the presence of strong, hostile, and aggressive feelings toward

an older, stronger brother with whom the patient had always been very competitive.

3. Jerry A., the third case, had expressed deep interest in religious conversion during his interview with the Protestant chaplain. Following up this lead, the chaplain was able to learn much of the dynamics of this boy's environmental background and personality development. It was revealed that conversion had the significance of rebellion against a strong dependent attachment to overprotective parents and, hence, expression and liberation of his individuality, which Jerry unconsciously felt was being smothered. The delinquent behavior of this boy, as one might suspect, had much the same basis.

Many other cases could be cited in which the chaplain's additional and unique information added greatly to the understanding of the boy and his difficulties, but these three cases serve to indicate two of the ways in which such studies are of value.

In emphasizing this new and additional function of the chaplain in the institution, depreciation of his traditional rôle as religious leader among the boys is not intended. This function should never be neglected or minimized.

The chaplains at the Illinois Training School for Boys function also as counselors and psychotherapists in certain cases assigned to them at the diagnostic staffing, much as cases are assigned to the psychiatric case-workers, psychologists, and psychiatrists. Psychiatric supervision is provided when needed for treatment cases carried by the chaplains. Individual treatment by the chaplain does not concern itself primarily with the religious aspects of a boy's life nor does it attempt merely superficial reëstablishment of moral and ethical codes. Social and personal readjustment and growth is brought about through understanding and through the proper handling of the conflicted and underdeveloped personalities of the boys so assigned.

To date, the dual rôle of the chaplain as diagnostician and therapist, on the one hand, and religious leader on the other has not proved conflictive, but on the contrary, has been mutually beneficial to both aspects of the chaplain's work. In fact, it has given the rôle of the religious leader a broader and more dynamic definition within an institution where the total combined efforts of all personnel are directed toward the rehabilitation of socially and emotionally maladjusted children.

REPORT OF AN EXPERIENCE IN THE APPLICATION OF DYNAMIC PSY- CHIATRY IN EDUCATION

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THE purpose of this paper is to report an experience the author had with five groups of teachers, totaling in all 229, in five different communities in Massachusetts during the past two years. The author met each of these groups for fifteen two-hour sessions in which an attempt was made to impart to them an understanding of the dynamics of human behavior, to help them understand the children in the classroom, themselves, and the interaction between themselves and their classes.

In working with disturbed children, we have noted that the failure of the teacher to understand the behavior of certain children frequently contributes materially to their disturbance and magnifies the problem with which the school has to contend. We often see school problems in children that are primarily created by the school through rules or procedures on the part of the school personnel that arouse resentful feeling and reaction in children, thus creating artificial disciplinary problems.

While it is rarely that we attribute disturbances in children primarily to the school, there are many instances in which a little understanding on the part of the teacher of the meaning of a child's behavior can contribute greatly toward helping the child to overcome or to handle the difficulties. We also know that many more problems arise out of the teacher's own personality needs to control children rigidly, to extract rigid conformances, to express sadistic feelings, or to receive evidences of affection from the children, failure to receive such evidences resulting in hostile, aggressive behavior on the part of the teacher.

The objective of the project was to see to what extent the feeling, thinking, and action of the teachers can be influenced by imparting to them an understanding of human behavior.

While no attempt was made to convert the teachers into psychotherapists, it was hoped that some method could be found to help them understand their interactions with the students, so that they would not be overwhelmed by some of the behavior problems in the classroom, would develop greater self-confidence in dealing with them, and in the end would not only do a better job with their children, but also be more comfortable in what they are doing. While we did not expect to change the personalities of the teachers with undue neurotic needs, we hoped that the increased understanding would help the average teacher to deal with average problems and to recognize the more severe problems that should be referred to experts in the field.

During the year 1948, the Massachusetts Society for Mental Hygiene was desirous of introducing mental-hygiene activities in the schools of Massachusetts, and had as its first project the introduction of the use of the Bullis material in the schools.¹ In attempting to use this material, they found that it was necessary to prepare the teachers not only technically, but in such a manner that they would themselves understand the material and the subject. There seemed to be little trouble in getting the teachers interested, but ways had to be found to present the material in an acceptable and digestible manner and to obtain the proper instructor.

It was found to be very desirable that the teachers obtain credits for the course toward university degrees and advancement. There was a long period of choosing instructors and negotiations with various authorities to accredit the course. The greatest difficulty encountered was the latter.

After many months of negotiation, the first group of teachers was organized in the town of Leominster, Massachusetts, by Dr. Libbie B. Bower, School Project Consultant of the Massachusetts Society for Mental Hygiene. The group was sponsored and the course taught under the jurisdiction of the Harvard-Boston University Extension Courses. The university advertised the course among teachers in the vicinity, registered the teachers, collected tuition, and paid the instructor.

Generally, the sponsorship by the university was a decided

¹ See *Human Relations in the Classroom*, by H. Edmund Bullis and Emily E. O'Malley. Wilmington: The Delaware State Society for Mental Hygiene, 1948.

advantage and relieved both the society and the instructor of all administrative responsibilities. The one disadvantage was that the university insisted upon a minimal registration of forty, which was more than double the number originally planned for by the author. The author had planned on groups of no more than from fifteen to twenty, which would permit of relatively free discussion and free interaction between the members of the group and the leader, with relatively little dependence upon didactic material. But since it was necessary to get the sponsorship of the university and they were unable to accept any smaller registration, some compromise method had to be used and, somewhat empirically, the author set up the plan employed.

The composition of the groups was mixed in many respects. They came from grade schools, junior-high schools, and high schools. They were made up mostly of teachers, with some principals, supervisors, guidance counselors, and school nurses. Many of them were well motivated by really being informed as to what to expect in the course and really sought to get something from psychiatry that would help them, but there were a good many members of the group who entered the course for the sole purpose of conveniently picking up a couple of university credits, which they may have needed for a degree or to satisfy the requirements of their school system for promotion or increase in salary. Most of them had little idea of what we were going to do or what kind of material would be presented. Most of them had had numerous courses in psychology and mental hygiene before, but none of them had ever been exposed to the dynamic approach to understanding of human behavior.

In every group, from 15 to 20 per cent dropped out of the course before the fourth session. This was permitted without loss of fee, and perhaps served as a safety valve to eliminate all people who might be too much threatened by the technique used. For statistical purposes, only those who finished the course were counted.

The first course was conducted in Leominster, Massachusetts, in the spring of 1949, and had 41 registrants. The second group, in Gardner, Massachusetts, had 54 members; and the third group in Needham, Massachusetts, 51 members. Both of these courses were held in the fall of 1949. The

fourth group, in Holden, Massachusetts, held in the spring of 1950, had 30, and the fifth group, in Dedham, Massachusetts, in the fall of 1950, 53 registrants. The total for all groups was 229.

The course consisted of fifteen two-hour sessions for which the university granted two credit hours and charged twenty dollars tuition for each student. This was later raised to twenty-four dollars. The university furnished a library suggested by the author. They also required that there be outside assignments, and while they did not specifically require any examination, they did require that each student be graded at the end of the course.

The library was made available to students, but no reading was required. Reading was suggested from time to time, but the students were definitely told that they were not expected to do any outside reading for the course. The thirty-hour period was divided as follows: approximately one-third to one-half was devoted to didactic lectures; one-third was devoted to discussion of the presented material; and one-third of the time was devoted to free discussion, interaction within the group, and discussion of the assignments.

The students were required to study two cases during the course. The first case was studied piecemeal, the assignments being made in each session for the succeeding session; whereas for the second case study, they were given a mimeographed form to follow. The students were told at the outset that there would be no examination in the class, but that grades would be based upon participation within the classroom and on the written assignments turned in.

The didactic lectures were planned in such a way as to present the genetic development of personality from the psychoanalytic point of view. The didactic-lecture material was organized as follows: The first lecture was an introduction in which the concept of the unconscious and its influences upon personality development were brought out. The author usually introduced the course with the statement that we live in an orderly world in which everything happens for reasons, although the reasons are not always apparent; that this is as true in human behavior as in other fields; and that the reasons for human behavior may not be obvious in consciousness, but that unconscious explanations always do exist for behavior.

Usually incidents in the classroom, such as certain habits, dress, and behavior of members of the group, were used for illustration. This worked rather well in that it readily enabled most of the members in the group to participate and break the feeling of distance between the author and the teachers.

The second lecture dealt with cultural, religious, and national predeterminants; the third, with the influences of attitudes of parents prior to conception and after conception, and parental reaction to the birth of the child; the fourth, with the constitutional, physical, and hereditary influences and the primitive needs of the newborn child. The fifth lecture continued the discussion of the primary instinctual needs of the newborn, and attempted to lay a foundation for the concept of instincts, instinctual drives, and their expression. The sixth dealt primarily with the oral needs; the seventh, with the early ego differentiation, the anal drives, and their part in later character formation, attitudes, and creativeness. The eighth, ninth, and tenth sessions were devoted to discussion of the Edipal period in both male and female and the importance of this period to the personality development and adult sexual attitudes. The eleventh dealt with the latency period. The twelfth and thirteenth were given up to a discussion of preadolescence and adolescence. The final two sessions were used to discuss certain specific problems of learning or other important behavioral symptoms that might not have been accounted for previously or that needed further emphasis.

The lectures would take anywhere from thirty minutes to an hour. The students were encouraged to interrupt and ask questions at any time. In some groups there were free interruptions with questions. In others the teachers would refrain from asking questions until they were specifically asked to do so. There was a liberal use of case material for illustration of various points and whenever possible some of the teachers' cases were used for illustrations. There was generally a pretty lively question period afterwards.

A great deal of stress was placed upon the two case studies the teachers were to do. They were encouraged to take children in their classes, but if these were not available, they could use as their subject any one with whom they had had contact who was not related to them or living in the same household with them. The first case was studied piecemeal, assignments

being made at the end of each session for the next session. In these assignments the attempt was made to help the teachers to focus finely, observe carefully, and make good use of what they saw or heard or felt. The assignments for the first case were as follows:

1. Description of the subject: Describe the subject as you see him or her and tell exactly what is going on as if you were painting a picture without giving any opinion or judgments, or entering into any conversation; purely observation.
2. Casual conversation with the subject, in which the conversation is entirely undirected without any interrogation. It can be a conversation of only a few minutes, but there should be a report of everything that goes on during this brief interval.
3. Brief interview with the subject in which direct questions are asked, but not of a personal nature.
4. Brief interview with the child in which direct personal questions are asked.
5. Observation of the child in a situation with other children.
6. Report of reactions of others to the child, and what they say about the subject.
7. Developmental history of the subject.
8. Family background, giving as much information as possible regarding family and their attitudes toward one another and in particular toward the subject.
9. School and health history of child.
10. Summary of case. Opinion of this case, conclusions as to what, if anything, is wrong with the subject and why, and suggestions for remedial measures.

The students were asked to turn in their papers at the beginning of each session and one or more of the papers were picked out by the author for discussion. The discussion focused upon whatever might be revealed in the paper about the teacher or the subject. The name of the teacher whose paper was discussed was never announced, so as to avoid undue embarrassment or anxiety. During the first few sessions, a great deal of anxiety was displayed when the various ways in which the teacher revealed her unconscious through her own writing were discussed. Many of the teachers, during subsequent sessions, held on to their papers until the end of

the hour in order not to have their papers discussed, and this was openly tolerated without criticism.

The second case study was assigned after the tenth session, and the teachers had five weeks in which to take care of that assignment. They were given a mimeographed outline to guide them, but were not expected to follow it rigidly. The outline was given to them as an indication of all the factors they were expected to consider, but they were to write up the case in narrative form in accordance with their own judgment. These case studies were most useful in judging the value of the procedure, in that the difference in outlook and attitude of the teachers in their handling of the first case against the second case was often quite startling and on the whole most encouraging. It is perhaps the one very definite indication that something happened to these teachers during those thirty hours.

The most difficult part of the program to manage was the group interaction. The author quickly gave up the idea of learning the names of all members of the group, and felt that it was neither possible nor desirable to force all members to participate in a group ranging from thirty to fifty-four.

After a few sessions, the anxiety seemed to increase and the group became reluctant to enter into much activity. After the first experience, it appeared desirable not to let a tense situation in the classroom carry over to another session, but to try to resolve the situation within that session. Care had to be exercised not to draw into the discussion extremely sensitive individuals, and gradually to rely upon the "good sport" concept in having teachers enter into group discussions. Hostility was not permitted to develop openly until the fifth or sixth session. Before this, any hostile remark would be ignored, but after this hostile feelings toward the leader were encouraged and explored with complete acceptance and approval.

Hostile attacks by members of the group toward one another were permitted to develop, but when the feelings got too strong, the leader came to the rescue with some interpretative remarks or by focusing attention upon a member of the attacking group. It appeared from later comments that these rescuing maneuvers by the leader were greatly appreciated and contributed to a very positive feeling toward the leader.

There were in each group at least one or more aggressive, hostile people with a need to annoy the group and the leader. It was impossible to ignore them, so the leader exposed them each time the attack came and the group seemed to coöperate wholeheartedly in each instance. It is not known whether this discouraged others from engaging in such tactics, or whether there just happened to be one in each group.

After two or three sessions these members quieted down, and in one case withdrew from the group. The one person who withdrew had apparently had a good deal of psychological training and came in with theoretical armament to serve his cause. He became so uncomfortable because of the hostility of the group that he disappeared after the third session.

During the didactic lectures and discussions the policy was not to introduce any new terminology—medical, psychiatric, psychoanalytic, or otherwise—unless it was absolutely indispensable for clarity, and then the terms were carefully defined. From time to time members of the group would use terms not used in the classroom and they would be asked to define and clarify what they meant as if the author did not know the meaning of the term. It was felt that giving them a new vocabulary would confuse them and perhaps become an obstacle to real understanding of the material.

Since most, if not all, of the teachers had never had any personal contact with a psychiatrist before, and did not know what to expect, there was great cautiousness at first. A good deal of scepticism was expressed during the first few sessions, as well as a great deal of curiosity as to what the function of a psychiatrist is. So far as it did not deviate from the main stream of discussion, an attempt was made to satisfy their curiosity and remove the halo or horns from the psychiatrist. No matter what happened, the author at all times showed an easy-going, patient, kindly, unruffled disposition.

The author frequently questioned what was done and attempted to get at the motives for certain behavior and incidents in the classroom, but was never openly critical. The class was conducted as informally as possible, yet in a dignified manner. The informality seemed in contrast to the teachers' previous classroom experiences and contributed to a rather relaxed atmosphere. Large, oversized rooms were

deliberately refused, and even though crowded, a smaller room was always chosen.

This easy, relaxed atmosphere allowed for the development of many situations similar to the situations one might expect to encounter in the usual classroom, such as boisterous conversations, which would delay the beginning of the class, delay in returning from the five-minute recess between hours, conversations by small groups that would disturb the rest of the group, and so on. These situations were deliberately encouraged and were used during discussion periods to determine their meaning and the best methods of handling them. The handling of these situations usually produced a good deal of anxiety, but with it there was spirited participation.

The author was always mindful of the usual personality make-up of teachers and their sensitivity to criticism, and so tried to evidence an understanding attitude toward their tasks and problems. The right of the teacher to be a human being and to express feelings in her work was constantly stressed, but the necessity for awareness of this need and of finding ways of expressing feelings with the minimum of harm to their students was also pointed out.

Questioning of the author's conclusions and of the material presented was repeatedly solicited. Even attempts to put the author on the spot by tangential questions were always accepted in good humor, with an attempt to work out the intent of the questioner at times, and the author's unhesitating admission that he did not know the answer when the question was not within his sphere of knowledge.

The course usually started out with pronounced reserve, followed by a rise in hostility to the author, the peak of hostility being reached around the eighth session, when the Oedipal conflict was discussed. During this discussion, there was almost unanimous ganging up of the group against the leader, though there were usually a few people in the group who identified strongly with the leader and came to his defense. In such instances, attention was usually turned upon the defenders, thereby making acceptance of the hostility more obvious.

After this session there always followed a session in which various members of the group would come out with evidence from their own experience confirming what had been brought

out regarding the Oedipal conflict, as if they had discovered the answer to an age-old riddle. From then on there seemed to be an increasingly warm, positive feeling for the leader and toward each other.

Two of the groups ended the course with a dinner and the third with a tea before the last class. These were arranged by the groups themselves. The first two groups also presented the leader with a gift after the final session.

It is rather difficult to evaluate how profitable this procedure has been without an actual controlled experimental set-up, which in this case would be a careful evaluation of each participating teacher and his work before and after the course. We were not able to do this, and to wait until resources for such controls were available would preclude ever trying it out. Unfortunately there was no way to find out if there were any negative effects, as none were evidenced or reported to the author. Neither is it possible to determine to what extent there may have been later misuse of the material by some of the participants, such as is noted in other students who acquire some intellectual insight. The evidence that suggests that the procedure was worth while is presented here, though admittedly it is not by any means conclusive.

The most positive evidence that something happened and that the attitudes of the teachers changed is revealed by the contrast in attitudes and language used in the two case studies. The first case study usually indicated a puzzled, sometimes hostile attitude toward a child who is "bad," "spoiled," "troublemaker," "lazy," and so on. The second case study displayed more feeling and understanding, and even though the conclusions might be entirely erroneous, revealed an attempt to see what is behind this overt behavior that is troubling the teacher and the child. The contrast between the two case studies of some teachers was quite striking. Much of this change in outlook was displayed in the class discussions, but this is extremely difficult to evaluate.

At the end of the last session, the teachers were given a two-page mimeographed questionnaire to fill out. This form was not to be identified at all and left ample room for spontaneous remarks. In presenting the form to be filled out, the leader jokingly called it an examination for the instructor, and stated that the information was to be used in guiding the

university and the instructor as to future planning of the course.

Unfortunately this survey, despite its anonymity, was not found to be very useful in that there was very little actual criticism and suggestion and the forms were filled with overwhelming expressions of positive feelings for the author. There were, however, numerous complaints about the author's low-pitched, sometimes waning voice, which made hearing at times difficult.

There were five complaints that too much time was spent on discussion of sex, a few complaints that there was not enough discussion, and equally as few that there was too much discussion. Only two indicated that they resented the personal nature of the discussions. All but one indicated that they had been helped by the course, but unfortunately the question was poorly worded and suggested a positive reply. Generally the replies were enthusiastically positive for the leader and the subject material. About 40 per cent expressed interest in a follow-up course.

Hearsay reports of the courses are received from time to time, but again the nature and source of them would preclude the possibility of their being other than favorable.

The author feels that this procedure was worth while, but that it should be studied further, and in particular should be followed up with more direct work with the schools and teachers, so that there will be a long, continuous experience, for which this procedure can serve only as a foundation.

A WORKSHOP IN MENTAL HEALTH*

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SEVERAL months ago the Human Relations Department of the National Board of the Y.W.C.A. devised a self-inventory test on inner security. This was used by club-leaders and residence directors as part of their program.

The inventory dealt with seven aspects of inner security: self-confidence, the feeling of belonging, health, making friends, liking people, dealing with one's anxieties, and a philosophy of life. Under each of the headings was a list of suggestions to help the club girl decide whether or not she possessed the characteristic described. For instance, under the heading of self-confidence, the individual was asked to list the things that she felt she could do well, such as singing, cooking, or typing, and to mark a column "yes" or "no" after deciding whether she did or did not have self-confidence.

This personal-inventory test was used in three of the young adult clubs of Harlem Branch of the Y.W.C.A. The findings from the inventory were both revealing and interesting. Many girls indicated that they did not find it easy to take their places in new groups; others stated that they wanted help in dealing with their anxieties, and the most frequently mentioned of these were not being married, loneliness, and meeting financial obligations. There were some who felt they needed help in developing self-confidence and a more attractive personality.

These responses had far greater significance and implications than would appear at a glance. Some of these young people had feelings of inadequacy, insecurity, of being discriminated against, and even of hostility, arising from factors beyond their control, growing out of the structure and pattern of our economic and social life.

Follow-up discussions with competent group leaders on some of these problems took place in the clubs. Mental-health

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discussions have always been a part of the program in both the teen-age and the young adult groups. It has long been recognized that the organized group is one of the most effective instruments for the reeducation, readjustment, and rehabilitation of the individual. In the controlled environment of the group, the growth of the individual is stimulated. In it he is able to achieve adjustment and satisfaction.

The vast majority of young women, possessing many of the same kinds of emotional and social problem, who live in our residence, attend classes in our health-education department and trade school, and seek jobs in our employment department, never get around to joining a club nor do they seek help with their difficulties from a trained counselor or social worker. Many of these same individuals, however, if given the opportunity, would participate in a group discussion and find within the group activities opportunities for new and satisfying experiences.

Through committee discussions, it was decided that there was a need for a mental-health program for young women who were not members of any club. The health-education committee undertook this project and the staff serving on the committee included the health-education director, the counselor, the residence director, and the young-adult director. A small steering committee was appointed to plan the project.

One of the first steps the committee took was to invite twenty girls from the residence to meet with some of the members. Our purpose in doing this was twofold. First, we wanted assurance that such a program would be of interest to the young women whom we were trying to reach. They were asked whether they would be interested in a series of mental-health discussions and whether they would be able to interest their friends. The second purpose was to ascertain what problems in the area of human relations they would like to discuss.

There was a good cross section in the range of interests, for included in the group were girls employed in the professional, business, industrial, and household fields. There were also college students as well as girls who had recently arrived in the city. Of the twenty girls invited, fifteen met with the committee and later became members of the steering com-

mittee. The other five girls were interested, but were unable to participate because of conflicting work and school schedules.

Many ideas were expressed by the group. There was general agreement on several points, one of which was that we call the project a "workshop." The objection to such terms as forums, lectures, conferences, which are commonly used by leaders in the field of mental health, was that they are frequently associated with formal academic work and one's job (the employer calls the worker in for a conference). The term workshop has not been overused and that in itself would create curiosity and stimulate interest in the project.

Another suggestion was that the workshop be coeducational. Since men have basically the same kinds of difficulty as women, the group felt that there would be value in sharing points of views. The director of the activities department of the Harlem Branch Y.M.C.A. was contacted and was most interested and enthusiastic. The mental-health project not only became co-educational, but was co-sponsored by the Harlem branches of the Y.W.C.A. and the Y.M.C.A.

A good deal of thought went into the discussion on the subjects to be covered in the workshop and the three general topics agreed upon were (1) Understanding Yourself and Getting Along With Others, (2) Finding Job Satisfaction, and (3) Courtship, Love, and Marriage. These suggestions laid the groundwork for the development of the project.

The task before the committee was a tremendous one and it proved to be beyond the resources and experience of the members. Since there was no trained and expert leadership on the staff to help plan and conduct the workshop, we turned to the New York State Society for Mental Health. In this community we are very fortunate in having the resources and services of this organization. The project developed beyond our expectations and it certainly would not have been so successful had it not been for the assistance, coöperation, and interest of the staff of the New York State Society for Mental Health.

We are especially grateful to Mr. William Beaty, the education secretary of the society, who worked with us from the beginning to the very end, and to Miss Fleming, special field consultant. During the planning process, we also had the good fortune of having Dr. Ross, the society's executive

director, give us the benefit of her thinking. As the project began to take shape, the New York State Society for Mental Health decided to make the workshop a pilot study in group education.

In the conferences that followed with the staff of the New York State Society for Mental Health, it was decided that the workshop would be conducted for a period of four consecutive weeks and would have as its general theme "The Art and Science of Effective Living," with three main topics: (1) "Do You Understand Yourself?" (2) "Do You Like Your Job?" (3) "Courtship, Love, and Marriage." The fourth session was a general discussion and a recapitulation of the preceding meetings.

It was agreed that we would have a coördinator for the workshop. Such a person would give continuity to the discussions, stimulate interest and participation in the project, and develop a sensitivity to the needs of the group. We were fortunate in securing Miss Louise Campbell, who has had much experience in group dynamics and who is a consultant in human relations to the New York State Society for Mental Health.

Time does not permit me to describe in detail each of these sessions, but I would like briefly to mention the techniques that were used. In the first session, on the topic "Do You Understand Yourself?" we used the film, *Preface to a Life*. This particular film was chosen jointly by the members of the New York State Society for Mental Health and the committee, after careful reviewing of several others, because we felt that the subject matter would provide a good springboard for discussion.

In the second session, on the topic, "Do You Like Your Job?" five young adults who had volunteered from the group served on a panel along with Mrs. Fortune, Employment Director of Harlem Branch Y.W.C.A. The occupational interests of this group included the fields of business, social work, nursing, journalism, law, and library science. The panel members were asked to tell what factors were responsible for the selection of their present vocations. For example, did they have any vocational counseling, or had there been some previous work experience that had been helpful in the selection of their vocational choice? The sharing of work experiences by

the panel members and the group stimulated a lively discussion.

At our third session, on "Courtship, Love and Marriage," there was a panel of three consultants—a young minister, the Reverend Galamison, who is a leader of a large church and has had much experience in dealing with the problems of young people; a sociologist, Mr. Sodofsky, who teaches a course in family relations at City College; and Dr. Magee, the health officer of the Central Harlem District.

The group was divided into smaller units of about eight young people each. Each unit selected a leader and a recorder and agreed upon three questions relating to the subject that they would like to have discussed. The coördinator then called upon the individual groups to read their questions and referred them to the panel of consultants for discussion.

At the last session, Dr. Milton Eisenberg, a practicing psychiatrist, was the guest speaker. All questions in the first three sessions that, in the mind of the coördinator, needed clinical opinion were held over for this final meeting.

As we went along, it was very important for the committee to have some gauge in order to judge whether or not the discussions were satisfying the needs of the group. We, therefore, asked members of the workshop at the end of each session to evaluate the meeting. Evaluation sheets were provided, containing the following questions: (1) What was your opinion of this meeting (please check—poor, mediocre, all right, good, excellent)? (2) What were the weaknesses? (3) What were the strong points? (4) What suggestions do you have for improvement? (5) Have you a question you would like to have discussed? A tabulation of the evaluations was made, and members of the committee, the coördinator, and the staff of the New York State Society for Mental Health met and studied the results and made any changes that were necessary before the next meeting of the workshop. A carefully prepared bibliography, compiled by the New York State Society for Mental Health, was distributed to the members of the workshop. There was a display in the room of a number of the pamphlets mentioned.

I should like to emphasize again that the workshop was an experiment and to some extent the registration was controlled. In the promotion of the project, we tried to interest the young

women in the residence, in the trade school, in the physical-education classes, in the employment department, and in the counseling service. The attendance at the first session was 81; at the second, 36 (the drop in registration here was largely attributed to the very inclement weather); at the third, 86; and at the fourth 82.

A brief mention of the method used in promoting the project may be of interest. We had posters and printed folders which were distributed throughout the administration building and the residence. One of the techniques that contributed most effectively to the success of the project was the personal approach to other girls by the committee members. This was done primarily by the residence girls, who assumed the responsibility for getting into contact with the girls on their floors. Registration sheets were provided, and where the girl expressed an interest, she was asked to sign. She secured her admittance ticket, however, from the counselor's office. There was a nominal fee of \$1.00 for the entire four sessions. Wherever possible, this technique of approaching young people personally was used. Members of the committee were stationed in the lobbies of the administration building and residence to register and give information about the workshop. Where girls had signed the registration sheets, but failed to obtain their admittance tickets, they were contacted again by committee members.

One of the plus features of the project was the light refreshments that were served either during the discussion period or at the end of the session. We found that refreshments contributed a great deal toward a relaxed atmosphere and provided members of the group with an opportunity for sociability not only among themselves, but with staff and guests.

I would attribute the success of the project to the fact that the young people themselves had a part in the planning of the workshop and were given specific responsibilities, such as setting up the room for the meeting, arranging the display, and conducting the sale of pamphlets and books, recording registration and attendance, serving refreshments, and cleaning up after the sessions. In addition, they helped to maintain the enthusiasm and interest in the workshop. Where young people have this sharing of experience—and for many of them

it was a new kind of experience—you are assured of their fullest interest and coöperation.

To sum up, in the workshop we aimed to give young women who were making use of our services, but were not necessarily members of any club, an opportunity to verbalize their attitudes and feelings on problems of concern to them. By exposing them to this group process, it was our hope that many would find a solution to their difficulties that would enable them to live a richer and more creative life.

From the enthusiasm and interest of the members of the group in all of the sessions and from the numerous requests for another workshop, we feel that our objectives were achieved.

BOOK REVIEWS

THE FORGOTTEN LANGUAGE: AN INTRODUCTION TO THE UNDERSTANDING OF DREAMS, FAIRY TALES, AND MYTHS. By Eric Fromm. New York: Rinehart and Company, 1951. 263 p.

"Tell me your dreams; and I can tell you what you are." "Dreams, like myths, are important communications from ourselves to ourselves." Now that the labors of Freud and his disciples in this field have made multitudes more conscious of this elementary truth, Dr. Fromm begins his own inquiry into the subject by voicing a wonder that modern man ever took so long to give it the serious study it deserves.

The Talmud said, "A dream which is not interpreted is like a letter which is not opened." In Plato's *Phaedo*, Socrates is made to say that dreams represent the voice of conscience and should be obeyed. In *The Republic*, he adds, "Even in good men there is a lawless wild-beast nature which peers out in sleep." Lucretius held much the same view. So did Artemidorus in the second century A. D. Two centuries later, Synesius of Cyrene added, significantly enough from the standpoint of the book here reviewed, that dreams may bring increased powers of reason and of insight.

Yet it was only in our own day that Freud, Jung, and other students, acting on such suggestions as the foregoing, gave the matter their close study. Freud presented a massive array of evidence in support of the thesis that dreams are façades beyond which certain experiences have been hidden—namely, the disagreeable or forbidden ones, and notably childhood encounters with sex. Jung was convinced that dreams, coming out of the universal rather than the individual unconscious, really speak, therefore, of religion. Fromm, whose *Escape from Freedom*¹ showed that this erstwhile disciple of Freud was breaking new ground in explorations of the psyche, here, in *The Forgotten Language*, again takes an independent stand and once more puts laymen as well as professional psychologists in his debt.

He holds that some modern discoveries are not to be found in any of the older theories; e.g.:

"Freud's principle of free association as the key to the understanding of dreams and his insight into the nature of the 'dream-work,' particularly into such mechanisms as condensation and displacement.

¹ New York: Farrar and Rinehart, 1941. Reviewed in *MENTAL HYGIENE*, Vol. 26, pp. 295-99, April, 1942.

"One of the two views that dreams are either manifestations of our animal nature—the gate of delusion—or of our most rational powers—the gate of truth—is held by most students of dreams. Some of them believe, like Freud, that all dreams are of an irrational nature; others, like Jung, that they are all revelations of higher wisdom. But many students share the view expressed throughout this book—that dreams partake of both, of our irrational and of our rational nature, and that it is the aim of the art of dream interpretation to understand when our better self and when our animal nature makes itself heard in the dream" (pp. 146-7).

With commendable modesty, that is, Fromm refuses to declare his view the only tenable one; and so he broadens the field of investigation by inviting us to look at the matter in which he is especially interested—the view, namely, that far from being confined to the origins asserted by Freud and Jung, dreams may arise from any mental activity whatever; that some of these may, to be sure, express such activity at people's worst, but that others also do this with a judgment and a clarity beyond those of ordinary waking life. Sleep, that is, by shutting out not merely the censorship of our conscious life, but no less the many noises and distractions of our waking hours, may bring us mental activities that are of a superior quality.

Familiar illustrations are the way in which an artist during his sleep may perfect a composition, a scientist or a mathematician put the finishing touches to a formula, a troubled soul see the best answer to his problem. "Unconscious cerebration," it was called in the days before these modern studies. Fromm defines dreaming as "meaningful expression of any kind of mental activity under the condition of sleep" (p. 25).

"We are not only less reasonable and less decent in our dreams, but we are also more intelligent, wiser, and capable of better judgment when we are asleep than when we are awake" (p. 33).

Some Freudians may bristle at a view that not only widens the field of emotional, irrational wishing and fearing, but that includes sound, rational insights as well. Just as Fromm takes a few dreams recorded by Freud, but gives them a different interpretation from the master's, so others will read Freudian symbolism into dreams that Fromm explains on other grounds. "Freud," he says, "ignores the fact that nakedness can be a symbol of things other than sexual exhibitionism. It can be a symbol of truthfulness." Anderson's fairy tale of the emperor's new clothes may be telling us not at all about exhibitionism, but rather about the debunking of irrational claims to authority:

"If some one dreams of being naked, this may express his wish to be himself, to give up pretense. His embarrassment in the dream may reflect the fear he has of the disapproval of others if he dares to be himself" (p. 91).

"It follows that one of the most significant and often most difficult problems in the interpretation of dreams is that of recognizing whether a dream is expressive of an irrational wish and its fulfillment, of a plain fear or anxiety, or of an insight into inner or outer forces and occurrences. Is the dream to be understood as the voice of our lower or our higher self? How do we go about finding out in which key to interpret the dream?" (p. 148-49).

Fromm replies that some dreams can indeed be explained in the familiar Freudian terms. Others may express wishes that are quite rational. Others may point to solutions of problems that have little or nothing to do with childhood sex experiences. Free association will help to the degree that it is really free, not tied to the interpreter's own assurance that the symbolism has to be sexual and nothing else.

With a view of this kind, few open-minded inquirers will be disposed to quarrel. The study of the psyche has brought to light much that was left out of the pioneer explorations of 1900. Much still remains to be done. Fromm wants the whole matter of symbolism to be reexplored. He takes exception to interpreting the *Oedipus* myth as a piece of incest symbolism, and believes that a study of the entire Sophoclean trilogy will show how the myth reflects a bias in favor of a matriarchal ethic rather than the patriarchal ethic that superseded it. He devotes one-sixth of his book to this, perhaps disputable, thesis.

What is gained, one wonders, by these guesses about myths? Where, when, why they arose, are matters of more or less interesting speculation rather than of science. If psychologists disagree about the results of psychoanalyzing even a single living person, how can we rely on the results of analyzing whole departed generations? Freud's *Moses and Monotheism* was full of assertions to which historians, archaeologists, anthropologists took exception. Fromm for his part says (p. 241) that Little Red Riding Hood is more than a symbol warning girls not to stray from the path of virtue, and that, like the *Oedipus* myth, it speaks of the male-female conflict. It is possible that some day he may be proved right. But it may well be also that "*the meaning*" of the fairy tale may never at all become a datum fit to be called scientific.

No matter how much or how little the fairy tales or myths may have sprung originally from the imaginations of gifted individuals, nevertheless, like the literary creations of historic times, they are of help in making more vivid what the artist wants to say. Fromm's findings on the rôle of loneliness in people's lives were anticipated by more than one novelist, poet, playwright. To record one's experiences or imaginings, however, is a different matter from giving these some one interpretation. Six interpreters may explain them in six different ways, depending on the total personality of the one who does the job. Doctors of the mind, all reputable and well-trained, have been known to suggest many different solutions of the same problem.

Fromm's book, therefore (it is to be followed by a second part) may perform a needed service in shaking some students if not out of dogmatism, at least out of the grooves of habit. As William James pointed out in his *Will to Believe*, those who fancy themselves highly rational may be as much influenced by their own basic, possibly very irrational, drives as those with whom they differ. Some attitudes are already *there* in one man, but not in another. Freud never convinced Jung that dreams come out of the individual's own wish-fulfilments. Jung, starting with his own "religious" predisposition, could never persuade Freud that dreams were sent by the wisdom of the universal unconscious. Conflicts between transcendental and empiricist temperaments are likely to continue.

Meanwhile it may be of use to remember that much psychoanalysis is still art, not science, and that suggestions for further study, like Fromm's, are to be welcomed for whatever of promise can be put to use.

HENRY NEUMANN

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REALITY AND DREAM; PSYCHOTHERAPY OF A PLAINS INDIAN. By George Devereux. New York: International Universities Press, 1951. 438 p.

Dr. Devereux, an anthropologist and psychoanalyst, has presented here a careful study of the psychotherapeutic problems involved in working with a patient from a specific culture. A detailed report of the counseling sessions (actually an exploratory psychoanalysis of brief duration) is given, together with reports on projective tests—Rorschach and so on. The symptoms for which the patient, an Indian living on a reservation, was treated were relieved through the counseling.

In the course of the therapeutic work, Dr. Devereux, who has extensive knowledge of and experience with the cultural psychology of the Plains Indians, found that his technique required modification in the direction of the psychological differences that exist between this minority group and individuals from a Western culture. These cultural-psychological issues and their therapeutic implications form the rationale for the volume.

For example, in handling the transference, the author found that he could use one based on the Plains Indian's familiarity with a guardian spirit which is acquired during the puberty of Plains Indians. Again, in working with the patient's dreams, the Indian's easy familiarity with dreams (particularly their manifest content) which are common currency for "testing" reality situations among this group, allowed the author to handle them in a way consonant with the place of dreams and visions in Indian life. In making interpretations, the therapist utilized the attitude of the Indian culture

which keeps their sexual life unencumbered by Anglo-Saxon puritanical defenses. All through the carefully worked-out treatment, the point is demonstrated that "knowledge . . . of elusive culturally determined basic attitudes and basic personality structure," as well as individual determinants in the patient's life, can be used in therapy.

The case lends itself well to the author's thesis that the "basic tribal personality" and, more significantly, the "areal cultural pattern or ethos" are of great importance in understanding and treating persons belonging to minority cultural groups. The Indian bred on a reservation is not a red-skinned "poor white," but an individual whose tribal and areal culture pattern are reflected in his psychological structure, symbolism, dream-life, psychosexual development, and ego-defensive system, and this must be understood when psychotherapy is contemplated.

In this connection, Devereux points out that the influence of infant care (pre-*Edipal*) on the developing personality among so-called "primitives" is immensely exaggerated over the influence of tribal and areal-cultural traits. In other words, whereas the emotional currents engendered by baby and infant care are decisive in the development of the basic character structure of children of the Western world, this cannot be said of the Indian. What is characteristic here is the influence of areal and tribal ethos. This comment presumably is aimed at the practice of translating psychoanalytic findings directly into findings among persons of another culture than our own.

There is much in this book of interest to those who are concerned with sociological and psychological marginal areas. The reviewer was particularly pleased with Devereux' analysis of the "white" attitude toward the Indian, compounded of "false perspectives, misconceptions, and prejudices" which are at variance with Indian realities. At a time when the Western Indians are trying once again to become Americans by relinquishing the "blanket life," attending American schools, and adopting American customs, the author's explanation of Plains Indian "ethos" is distinctly timely. The deep psychological chasm that separates the native American from the American native is still present and Devereux' understanding of it and its determinants is a step that may help to close the gap. The book requires close reading, but is worth the effort involved.

WALTER BROMBERG

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THE MODERN FAMILY. By Robert F. Winch. New York: Henry Holt and Company, 1952. 522 p.

This book is mainly concerned with the rôle of the family in the development of personality. The major thesis is that our personality is largely the product of organized social life and primarily the

product of family life, since we do our first learning through the family, and the family satisfies our earliest needs.

Part I furnishes a general theoretical account of the family as an institution and suggests the range of possible variation in its structure and functions. Part II focuses on the family in the United States, indicating how the family has changed, especially in its functions, and what the consequences of these changes have been. Parts III and IV, the heart of the book, are concerned with the development of personality in the family. Part III deals with the growth of the individual from infancy to adulthood, as influenced by the family; hence the accent is on parent-child relations at the successive stages in the life of the individual: infancy, early childhood, adolescence, and adulthood. Part IV develops the second phase of the affectional cycle—namely, dating, courtship, and marriage. The concluding Part V consists of a single chapter on the nature and causes of family breakdown.

It is in Parts III and IV, dealing with the several stages in the affectional cycle, that Professor Winch makes his principal contribution. He combines clinical reports and psychoanalytic theory with experimental data. For instance, in discussing the effect of parent-child interaction on the personality of the child, he describes the studies of Ribble and Fries and then shows that they have been insufficiently tested and verified. If the reader wants a digest and interpretation of the best thinking and data on the development of personality in the family setting, he will find it in Winch's book.

The foregoing section is well done, with major problems clearly delineated and the best available evidence brought to bear upon them. The more original contribution, however, appears in Part IV, on "Courtship, Love, and Marriage," the second phase of the affectional cycle. Here the choice of a mate is set forth in terms of "cultural expectations and psychic needs, of gratifications and frustrations." The argument is that all behavior is grounded in needs, and love is no exception. Socialization in middle-class America results in a need for acceptance and security which is expressed as a need to love and be loved. The structure of the ego ideal determines the characteristics of the person to whom one is drawn. Winch, in his theory of "complementary needs," holds that mates are selected in part on the basis of unconscious emotional needs. Those who gratify each other's basic needs tend to choose each other. If these needs are not met, trouble ensues. The problem is one of reciprocal satisfaction.

This theory of Winch's is, it would seem, subject to the limitations of the real world—that is, the realistic opportunities for choosing a mate available to most young people. The question arises as to how much choice the average young man or young woman actually has. Choice is limited by the number of acquaintances one has, by propinquity, by whether they are of acceptable marital, economic, religious,

and social status, and so on. The actual range of choice may be very narrow, and within this circle there may be no one who meets one's emotional needs very well. The theory of needs is useful for understanding why conflict develops in many marriages.

The Modern Family has many characteristics of a good book. It is concerned with significant problems, is clearly written, well organized, reliable, and comprehensive. The book is intended primarily as a college text, but it can be recommended as worth-while reading for the intelligent layman who wants to know what science has to say on the problems of love and marriage.

M. F. NIMKOFF.

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PATTERNS OF MARRIAGE. By Eliot Slater and Moya Woodside. London: Cassell and Company, 1951. 311 p.

Patterns of Marriage is a study of marriage relationships in two groups of 100 soldiers each, admitted as war casualties to a large London hospital. One group consisted of neurotic, the other of physical, casualties. Both the soldiers and their wives were questioned on many aspects of their married lives: how they met, their early childhood and premarital lives, reasons for marrying, sex life in marriage, contraceptive attitudes and usages, happiness in marriage, and various social attitudes and values. The families studied were mostly lower middle-class. One of the authors is a psychiatrist; the other, a psychiatric social worker.

This is a significant book, and for a number of reasons. It is the first psychiatric investigation into working-class marriage relationships to be undertaken in Great Britain, utilizing modern insights and techniques; it is, so far as this reviewer knows, the first comparative study of neurotic and "normal" married life; it gives a picture of lower-middle-class life in London during the period between the two World Wars; it reveals the pathetic lack of preparation of young people for the realities of married life; it makes clear the cramping effects of environment in many homes; and it shows the lack of contraceptive and other knowledge pertinent to the processes of human reproduction.

Particularly valuable is the long-range view that one obtains of the lives of the persons involved: the often far from happy childhood, the stark incisiveness of the home life, the adolescent romances of the street, the stumbling steps into marriage, the fear of pregnancy, the effects of the war, against the background of a negative hope that "to-morrow will be better." One sees, too, the blighting continuity of mental illness, the neurotic parent complicating the lives of children, who in turn pass on to the next generation complications alike in kind.

The book is dotted with flashes of insight that carry the reader from one group of facts to another. It is well written, with statistics, insights, illustrations, and summaries in excellent balance. Meticulous technicians in research will be pleased with the 30 pages of exposition of how it was done.

JAMES H. S. BOSSARD

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THE ADOPTED FAMILY. By Florence Rondell and Ruth Michaels. New York: Crown Publishers, 1951. Book I, *You and Your Child. A Guide for Adoptive Parents*, 64 p.; Book II, *The Family That Grew*, 22 p.

Because there are very few really good books on the subject of adoption, the eminence of any newcomer may well be due to the flatness of the surrounding territory. Although several excellent presentations dealing with various aspects of adoption have been written for the professional worker, there is distressingly little material that is suitable for the non-professional person who has an interest in the problem; and there is even less that the worker can, with confidence, place in the hands of prospective adoptive parents. The few books that are available in this area are either so broad and non-specific in their approach that a well-selected volume or pamphlet on the basic problems of child care in general would be equally suitable, or else they deal with the problems of adoption largely in sentimental terms which leave the reader little the wiser as far as his own particular problem as an adoptive parent is concerned.

The present volume has the happy or unhappy distinction of falling somewhere between these two extremes. Although it does give some rather practical suggestions regarding the problems of care peculiar to adoptive parents and their children, it nevertheless leaves the thoughtful reader who already has at least some understanding in the field of child psychology with a vague feeling that the book has somehow failed to meet his needs.

The Adopted Family comes in a set of two small volumes: Book I: *You and Your Child: A Guide for Adoptive Parents*, and a companion volume, *The Family That Grew*, a slim picture-book with written continuity, supposedly suitable for the young adopted child's own reading or else to be used as a "Read-me-a-story" volume for the good-night story hour.

The usefulness of Book I will depend, of course, upon the reader's demands and needs. For the reader not vitally concerned with more fundamental problems, some of the suggestions on methods of announcing the coming of an adopted baby, with specific forms sug-

gested for printed-card announcements, may constitute the high spot of the book. Worried would-be adoptive parents, however, may find the discussion on the legal aspects of adoption (*See Your Lawyer!*) somewhat less than helpful. On the other hand, some of the definite recommendations are excellent, particularly those regarding techniques of treating specific problems, such as what to tell the child himself and how to answer the questions of friends and relatives.

The suggestion is made, for example, that we attempt to identify biological parents with the adoptive parents, because such an attitude accentuates resemblances and makes it easier for the child to identify himself with his adoptive parents: "I don't know [in answer to the child's question as to what the biological mother was like], but I think she must have been very much like me." Similarly, the authors make the wise suggestion that it be emphasized to the child that his biological parents were willing to part with him, not because of any fault in him, but only because, for reasons beyond their control, they were unable to care for him.

The chapter, *Answering the Growing Child's Questions About His Adoption*, is the best section of the book.

Any volume on adoption, however, is fundamentally an attempt to deal with a problem fraught with all of the basic frustrations of childlessness and with their attempted solution through a complex social maneuver; and, as such, it must consider more than the legal mechanics and the question of what to say when the neighbors raise their eyebrows.

In *The Adopted Family* little attempt appears to be made to gain or to give insight into the feelings or attitudes of the human beings involved or into the complicated emotional cross-currents of adoption. The authors seem to assume that adoptive parents are themselves without self-questionings, doubts, or misgivings, and that the adoption process is a matter-of-fact procedure devoid of emotional overtones. It seems probable that the authors postulate greater emotional maturity on the part of adopting parents than they ordinarily possess. The authors provide ready answers for the parent to give the adopted child. They also provide ready answers to give to questioning adults, friends, neighbors, and other members of the larger family to whom the adopted child is sometimes a threat. When we look in *The Adopted Family* for a discussion of more fundamental concepts, however, we note a lack of emphasis upon the understandings and insights that could give basic security to the rôle of adoptive parenthood, and a failure to encourage adoptive parents to develop those attitudes of self-understanding which alone can still questioning and doubt.

Book II, *The Family That Grew*, devotes much space to emphasizing the "bees-and-birds" type of discussion of human origins—space that

probably might better be spent on something more closely related to substitute parenthood. The volume itself, although intended for the young adopted child, is inferior to Wasson's *The Chosen Baby* in organization and even more so in format and illustrations.

The conscientious professional worker will do well to consider the present volumes as a helpful adjunct to, but only a minor part of, the education and indoctrination process for adoptive parents.

ARTHUR L. RAUTMAN

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CHILD PSYCHIATRIC TECHNIQUES. By Laurettā Bender, M.D. Springfield, Illinois: Charles C Thomas, 1952. 335 p.

Of the nineteen chapters in this book, four contain material not previously published, while the others are reprinted, or revised and enlarged, from previous publications. The material that Dr. Bender has compiled or rewritten was originally written by herself or by Dr. Paul Schilder or by both together, with the help of some of their associates, and for the most part is based on the study and treatment of some 8,000 problem children who were patients in the children's ward of the Psychiatric Division of Bellevue Hospital, New York, during the last fifteen years.

While the first chapter is largely a survey of some of the techniques generally used for diagnosis or therapy in psychiatric work with children, it also includes a classification of the problems of children brought to the ward in Bellevue, a brief discussion of their therapeutic needs, and an outline of the program required to meet these needs.

Seven later chapters (12 to 18, inclusive) are devoted to a more adequate description of the inpatient therapeutic program at Bellevue. Group activities and group therapy are emphasized, supplemented by individual psychotherapy "where it is indicated" (p. 205). Separate chapters are devoted to certain of the group activities, such as art classes, dancing, and puppet shows. Another chapter reports in considerable detail the therapy of one child. There is a short account (Chapter 17) of Manhattan Public School 618, a special school located in the Bellevue Hospital Psychiatric Division.

Reading these chapters descriptive of the Bellevue residential service, and recalling what the Bellevue children's ward was like in its beginning some thirty years ago, one realizes that what has been accomplished under the leadership of Dr. Bender and, until his untimely death, of Dr. Schilder, is truly impressive.

In reviewing the high lights of the chapters on inpatient therapy, it is interesting to note the statement that chemotherapy, narcotherapy,

and shock therapy have not been found successful by themselves, but may be important in facilitating, and hence shortening, psychotherapy (p. 29). Even more interesting is the statement (p. 30) that case conferences in which the child appears are of therapeutic value to the child. A later paragraph (pp. 203-204) tells a little more about conducting staff conferences with children present. This procedure might well have been more extensively discussed, for there is danger that it might be non-therapeutic unless carried out very skillfully.

The other eleven chapters in the book (chapters 2 to 11, inclusive, and Chapter 19) are more generalized presentations of theories, techniques, and research findings. Several of these chapters indicate the influence of Gestalt psychology on the viewpoints and techniques explained. For example, chapters 2 and 3 emphasize the principle of form in the play activities and sidewalk drawings of children, while chapters 4 and 5 discuss the usefulness of the visual-motor Gestalt test as one of a diagnostic battery, and the types of response to this test frequently seen in such conditions as mental deficiency, schizophrenia, psychoneurosis, and so on.

There are several exceedingly interesting chapters on art. Dr. Schilder, the author of Chapter 5, drew largely upon Freudian theories in formulating interpretations of the characteristics and meaning of art works of children and schizophrenics, but also contributed original observations. For example, he called attention to the strong resemblance between art forms of schizophrenics and children and primitive art forms. He noted that children try to draw people and things as they really are, even though not always having ability to draw them realistically. Thus children's artistic efforts offer a way to increasing contact with reality. Art productions of schizophrenic or otherwise mentally ill adults or children may represent a retreat from reality or a picture of the distorted forms that reality assumes for the mentally ill person, according to Dr. Schilder, but they may also be an effort to regain contact with reality or to communicate with other people.

Chapter 7 continues the discussion of art by examining the meaning of the drawings and paintings of several patients. The chapter ends with the conclusion that, in analysis or psychotherapy, the art productions of patients are to be regarded as similar to the manifest content of dreams and can be utilized in the therapeutic procedure in the same way as dreams.

Chapter 8, by Dr. Bender, describes the performance of five children suffering from some type of chronic encephalitis who were asked to draw a man. Their Goodenough scores were lower than their scores on other intelligence tests and their drawings of the human figure were

extremely inadequate as compared to their much better drawings of other things. Dr. Bender, therefore, suggests that the trouble they had in drawing human figures was due to difficulties of perceptual integration connected with their own body image rather than to any difficulty in perception of external objects.

Dr. Bender and Dr. Schilder collaborated on studies of the art work of high-grade mentally defective children, reported in Chapter 9. They conclude: "Art is a means of expressing the inhibited aggressive drives of mildly retarded and schizophrenic children and depicts their struggle with emotional disorganization and their primitive perceptual experiences" (p. 164).

Chapters 10 and 11 summarize research on the significance of boats and animals in the art and fantasy of children. It appeared that the boat represented the mother, with the child inside, for child patients, while in adult fantasy it symbolized the female genitals and sexuality. Many children who drew horses and birds had histories of truancy or vagrancy. Cats and dogs, drawn by children from broken homes, seemed to symbolize the wish for a secure home. Only 10 per cent of 75 animal drawings were of aggressive animals; these symbolized different things for different individuals.

The nineteenth and last chapter, written by Dr. Paul Schilder, is a further exposition of his theories, not only of the art of children, but of modern art in general. It is short, but rich in content, so that quotations cannot do it justice. It must be read *in toto* to be adequately appreciated.

Perhaps this last statement should be made of many other chapters in the book. Indeed, any one who is engaged in psychiatric work with children should find the reading of all the chapters rewarding and well worth the time so spent.

PHYLLIS BLANCHARD

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JUGENDPSYCHOLOGIE (Psychology of Childhood and Adolescence). By

Dr. Erich Stern. Stuttgart: Hippokrates-Verlag Marquardt and Cie, 1950. 164 p.

This slender volume pieces together in survey form the leading contributions made by modern psychology to the study of child development. The author presents a history of child-study methods and their foundations in philosophy, educational theory, clinical experience, and experimental investigations. From Pestalozzi's and Rousseau's theories of education, the reader is guided to Froebel's observations on the different phases of human development. The diary methods of William and Clara Stern are discussed, and the

systematic experimental method inaugurated by Wundt and his followers is described. A brief account of the world's centers of child observation—Gesell's Institute at Yale and the Institut Jean Jacques Rousseau at Geneva—completes the historical section of the book.

The successive phases of child development—infancy through adolescence—are discussed in the second part of the book. Dr. Stern describes emotional, intellectual, and behavioral aspects in the light of ideas formulated by various schools of psychology and psychiatry. He draws on psychoanalysis, on individual psychology, on Gestalt and field theories. Behaviorism, Rank's birth-trauma theory, and various other contributions are also included. In addition to the "schools," the work of individuals such as the William Sterns, Piaget, Claparede, Gesell, the Bühlers, and so on is fitted into the author's chronological account of the subject and its science.

In its wide coverage and small size, the book is comparable to a map pointing out the locations and directions of psychological trends and their relationships to one another. It makes for pleasing and trustworthy reading on present-day knowledge about personality development. As such it might be helpful reading for teachers.

Published in its fourth edition in Germany, the book draws on a representative number of French, American, and English works as well as on German authors, many of whom have been familiar faces on these shores since the thirties and are now to be counted as American scientists. While the fund of information in this book is multi-national, certain aspects of specifically local significance speak for the European atmosphere out of which it emerges. In these passages the author touches on race psychology and its support of master-race ideology, which, of course, he discredits and deplores.

The subject matter of such a book certainly warrants a large circle of readers. There is always a place for an intelligible and interesting work on child psychology for teachers, social workers, and parents. There is also room for another good text for the beginning student in child study and related fields. This book in its present form cannot meet the standards of a work of general interest, nor those of a teaching text in this country. From the layman, too much background information is required and too much patience with some slow, plodding passages. As a textbook it is impractical because it is too sketchy and lacks an author-subject index. Nevertheless, the book gives an informative bird's-eye view of child psychology, and it can suggest and stimulate further reading.

RENEE G. REENS

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ADOLESCENCE. By Marguerite Malm and Olis Jamison. New York: McGraw-Hill Book Company, 1952. 512 p.

Here is a new book about the psychological side of the growing teens that will surely have wide appeal and use. The general format is excellent, matching that of the best college textbooks in the field, and the clarity and interesting style of every paragraph reveal the high literary skill of the authors.

The volume is quite complete within its covers, with a 750-item subject index and about 250 names in that index. The book is profusely illustrated with real-life cases, and many tables, charts, and diagrams to clarify relationships. Every chapter includes detailed discussion questions plus many up-to-date references to guide further reading. All these things will delight the academic mind; certainly they are important points to be sought in any text of this kind.

The pleasant addition in the case of this particular book, however, is its combined easy readability, its warmth toward the subject, and its down-to-earth practicality. Every chapter is firmly based and buttressed with sufficient "formal data," yet the array is not put forth in stilted fashion. Just to test its readability, this reviewer offered the book to several young people of from sixteen to twenty. Their responses all were in terms of real interest aroused by many sections of the book. While the authors have not attempted to compress into one volume the whole area of the psychobiosociology of adolescence, the book still comes very close to being a "one best source" of such information.

The major divisions of the book are *Introducing the Adolescent*, *The Adolescent and His Adjustment*, and *Major Influences on the Adolescent*. The chapters are not merely an account of the various changes a teen-ager is likely to undergo at specific times and in specific situations. Much more than such an account, this book provides an important parallel stream of educational and social philosophy, as a backdrop against which to view what may be normal, healthy adjustment in the growing young person. Pointers for therapy are well integrated throughout the book with the problems under discussion at the moment.

Part I covers who is the adolescent, why study him, and the broad world of the adolescent. Part II continues with full discussions of the many aspects of growing up physically, social adjustments, heterosexual adjustment, emotional adjustment, adjustment to life value, personal adjustment, vocational adjustment, and finally a carefully detailed chapter on juvenile delinquency.

Part III pulls together the major threads and ties them into a practical philosophy of education that contributes greatly to the application values of this book. Chapters in this section discuss the adolescent's relationships at home, out in the community, and at school.

The text is free from the animistic concepts so prevalent in books that are highly psychoanalytically oriented. This, however, seems to be no loss so far as this book is conceived. It may, indeed, be one of its advantages, to the parent, the teacher, and the clinician who reads it.

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CHILDHOOD PROBLEMS AND THE TEACHER. By Charlotte Buhler, Faith Smitter, and Sybil Richardson. New York: Henry Holt and Company, 1952. 372 p.

This book is in excellent format, beautifully arranged and very clearly printed. The general arrangement and organization also are good. There is no indication as to which author is responsible for which part of the book, but the differences in philosophy and style of writing show up readily in different sections.

The first eight chapters represent a theoretical presentation and are apparently written by the psychologist author. This section is over-classified and confused. There is a hodgepodge listing of symptoms in a disconnected way, which gives the reader the impression that the whole field is chaotic. Nowhere is there any indication of the possibility of understanding the dynamics of childhood behavior according to an orderly, predictable system, such as is available at the present time. There are repeated attacks upon teachers, in which they are represented as ignorant, incompetent people who do everything wrong, in contrast to the psychologist, who knows everything and always has the right answers. Rarely is any credit given to other people in the field.

The author seems to expect too much from the teacher; fails to explain a good many points, but at other times does entirely too much hair-splitting. There are many case presentations, and the repeated references to the cases, instead of being clarifying, rather adds to the confusion.

If the reader survives the first eight chapters, however, he is well rewarded by chapters 9, 10, 11, 12, 13, and 14, which are excellently written, without the pedantry so annoying in the first eight chapters. There is evidence here of an experienced, understanding, mature author, with creative ability and good judgment, who uses the case illustrations in a simple, understandable way that will readily be helpful to the teacher.

The last chapter is on projective technique and it is doubtful whether it belongs in a book for teachers.

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JOSEPH WEINREB

THE RIGHT SCHOOL. By Clara F. Blitzer and Donald H. Ross. New York: Metropolitan School Study Council, 1951. 84 p.

Some of us may welcome the dialogue form of *The Right School* as "extremely readable"; others of us, who prefer our information "straight," may resent it as "sugar-coated." But all inquiring teachers and parents will recognize, within the unpretentious format of this paper-covered volume of less than a hundred pages, urgently needed and meaty information about the kind of school they should want for their children.

This information is conveyed through several informal discussions held by four people. Ed and Mary Stuart, a couple in their thirties, college-trained, forward-looking, with two young children, are seeking a home in the suburbs. Having faith in the value of education, and knowing that their choice of a locality will depend on the quality of the school, they seek the advice of a friend, George Burke, a city school principal, as to what they should look for in a good school. George Burke and his wife, Nancy, though "confirmed city dwellers," have values similar to those of the Stuarts, and want the same things for their children. The discussions, thought-provoking and fruitful in clarifying criteria, culminate in a check list—"A Guide for Assessing School Quality."

Adequate physical facilities advantageously used; suitable, appropriate furniture and equipment for carrying on a modern program of education; an ample school budget—these are the *sine qua non* of the right school, on its material side.

More important than these, though dependent on them, is the quality of the instruction. Are individual needs and abilities considered, or is there uniformity and regimentation? In other words, does the school provide "custom-made or ready-to-wear education"? Do the pupils' interests determine the way in which the basic skills are taught? Do the learning activities arise out of real-life situations and are they thus made meaningful? Is there an attempt to have children gain an understanding of basic principles instead of merely mastering facts? Are the so-called "fads and frills" of education—music, art, dramatics—stressed, in addition to the three R's, so as to develop well-rounded individuals? Affirmative answers to these questions would indicate an attempt to educate the children both intellectually and socially.

But most important of all is the emotional climate of the classroom, which must be a healthy one to foster good character and personality development. And here the teacher plays a major rôle. If she is a mature, all-round person, with a great variety of interests, if she is alert to the exceptional child so that she can help foster individual talents and abilities, if a democratic administration allows her to be

free, if she can keep from dominating the classroom situation and, in her rôle of guide, encourage self-activity on the part of her charges, and if she possesses a fine sense of values that is unconsciously transmitted to her pupils—the climate of her classroom is bound to be wholesome.

These are challenging times for the schools. The need is great for proving themselves to the tax-paying public. With the publication of *The Right School*, the Metropolitan School Study Council has risen to the occasion, for *The Right School*, in a novel way, explains the newer type of education, which seeks to develop, through its democratic methods, its variety of subject matter, and its respect for the individual, clear-thinking, self-directing, emotionally mature people equal to coping with an anxious age such as ours.

IDA KLEIN STERNBERG

New York City

GROWING IN THE OLDER YEARS. Edited by Wilma Donahue and Clark Tibbitts. Ann Arbor: University of Michigan Press, 1951. 204 p.

This informative volume contains thirteen addresses presented at the 1950 Institute of Aging held at the University of Michigan. It is the third in their series dealing with the later years. The broad scope of the material covers many of the dynamic problems relating to enlightened consideration of our rapidly increasing population of older people.

A foreword by Everett J. Soop, director of the university extension service, indicates the focus of attention on mental hygiene, physical health, and education. We can conveniently consider the content under those headings. The preface, by Wilma Donahue and Clark Tibbitts, states the purpose of the book—that of giving intensive consideration to problems identified by older people themselves as crucial in their adjustment to aging. In the preliminary discussion, Mr. Tibbitts deals with the national aspects of an aging population.

Mental health in the aging receives its warranted conspicuous attention, different aspects being considered by three authors familiar with the problems. Robert H. Felix, M.D., M.P.H., shows the effects of our changing social and economic background on the mental health of our vast and diverse group of aging people, with their individual needs for health, economic security, useful activity, a home, independence, and self-respect. The particular emotional needs of the aging, who are commonly concerned with fears of loss of control over life situations and of physical incapacity, are described by Moses M. Frohlich, M.D. Major psychological defenses used by older people

to escape emotional conflicts are considered, by Jack Weinberg, M.D., to include regression, personality rigidity, and the exclusion of overwhelming stimuli. Electric-stock treatment, direct psychotherapy, program planning, and other psychiatric techniques are discussed in the treatment of the aging.

The paramount problems of physical degenerative disease are presented critically by William B. Kountz, M.D., who, from his experience in research and medical practice, finds good reason to believe that chronic illness is to a large extent reversible with increasing knowledge of the glands of internal secretion, metabolism, and the mechanisms of nutrition. He notes the further important point that an increasingly productive approach to the problems would stress physiology or function rather than the anatomical aspects of the aging body.

The importance of community-health services is outlined by Joseph W. Mountin, M.D., who suggests local public-health organizations as a generally well-established framework of assistance for programs of periodic health appraisals, medical care, and rehabilitation. The rôle of the industrial physician is described by Newton E. Leyda, M.D. More realistic points of view toward employment are stressed, such as that of allowing the aging person to continue work after the usual retirement age when his inclination and capacity permit. Methods of physical restoration of the aging to greater fitness are elaborated by Michael M. Dacso, M.D., who lists more than one hundred exercises and activities in self-care, locomotion, travel, and hand activities.

The reader's attention is next directed to the great importance of educational activities, with regard both to the function of education in enhancing the values of life for the older person and to the training of those people or groups in the community who are interested in the care of the aging. Numerous discerning comments, derived from experience and careful thought, are presented by educators prominent in many fields. Thomas A. Van Sant indicates that aging itself does not preclude the quick and thorough learning of interesting subjects. He refers to the greatest present relevant contribution of adult education as that of focusing coöperative efforts on delineating the full aspect of social, economic, and political problems in middle-aged and older adults, with subsequent planning of programs in coöperation with other community groups.

Problems in the organization and administration of educational programs for older people are considered by Everett J. Soop to be basically the same as those of programs for younger people. Roger W. Heyns discusses the value to older people of close group participation, especially in performing functions useful to the community. Miss Ollie Randall, from her years of experience in community service, is uniquely able to appreciate the new problems of establishing methods.

and of actually training volunteers to work with this large group of the aging, who have perhaps more combined needs than any other social group.

The concluding chapter, entitled, *A Mid-Century Forecast for the Aging*, by Wilma Donahue, predicts the great progress that now appears possible in the next fifty years: unprecedented maintenance of health, extension of the period of physical vigor and longevity, retardation of physiological aging, reduction of chronic disease, and social and economic stability.

This volume is well worth reading for its presentation of trends, as well as for the specific information it gives, and its provocative consideration of the future of the aging in our culture.

HOLLIS E. CLOW

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COMMUNITY SERVICES FOR OLDER PEOPLE. By the Community Project for the Aged of the Welfare Council of Metropolitan Chicago. Chicago: Wilcox and Follett, 1952. 240 p.

This book has an important place in the series of sociological studies based on direct observation of a community by its own citizens, led by professional investigators. The technic has developed relatively recently and has certainly not yet reached its full stature. There can be no question of its value as a powerful device for public education, as well as a method for collecting valid data for the building of hypotheses in the study of human dynamics.

The present study deals with the community services for older people in Chicago and its metropolitan area. It explores the size and character of the problem, from the economics of the expanding systems of social security to the needs of the financially secure older person, from the housing of the destitute older person to the programming of life within the well-maintained institution for the aged. Data are collected from social agencies, but—and more important—also through special investigations of several hundred older citizens of the area. The findings are projected against known figures for the state of Illinois and the United States as a whole, when these are available, which is all too rarely.

As each of the many sections is discussed, certain recommendations are made. These are collected in a separate chapter later on. The fact that the research received the active collaboration of many front-line working organizations and personnel tends to make the recommendations practical next-steps, rather than magnificent utopian, reorganizations. The book is quite frank in revealing the suspicions:

that had to be overcome before some groups could collaborate. This is perhaps most apparent in the section on institutions for older people.

It is characteristic of the period in which social and health problems are first recognized that their importance is pointed out with more enthusiasm than facts, with more insistence than practical suggestions for methods of working. This book demonstrates the growing maturity of the field of work with older people by presenting a complete survey and being able to offer recommendations for steps to be taken in dealing with the various problems in it, to the end that the total health of the community may be enhanced.

PAUL V. LEMKAU

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PSYCHIATRIC ASPECTS OF JUVENILE DELINQUENCY. By L. Bovet. Geneva: World Health Organization, 1951. 90 p.

Bovet is consultant in mental health to the World Health Organization which commissioned him to prepare this monograph as a comprehensive summary of the most widely accepted psychiatric views on juvenile delinquency. It was to be "not of a strictly scientific nature, but rather a broad picture for the intelligent reader without psychiatric training."

The monograph is based on Bovet's travels through several European countries and America, consultations with over 150 specialists in various fields of juvenile delinquency, and visits to 60 institutions. He offers a bibliography of 140 references in four languages. It is indeed remarkable that he was able to complete this stupendous task in less than a year and to summarize it in such a compact form. This translation from the original French to English is in clear, non-technical language which any interested reader will have no difficulty in following.

In the introduction, Bovet properly emphasizes the many difficulties that beset the subject of juvenile delinquency. For instance, there is such a large variety of factors to be taken into account that there are many chances of error creeping in. Then there is the fact that even scientific workers have difficulty in approaching the subject in an objective way. The author himself unwittingly demonstrates this. On most controversial subjects he is careful to quote adequately different points of view, but in discussing the subject of "psychopaths," he devotes several pages to an attempt to convince the reader of the "constitutional" nature of the condition, making only passing references to the existence of views attacking this hypothesis.

The reader for whom this monograph is intended would benefit from a revision of Bovet's development of some of his points in the chapter

on etiology. For instance, he quotes extensively, and apparently approvingly, those sociologists who speak about "normal" delinquents —i.e., those presumably without demonstrable psychopathology who come through with antisocial behavior only when they are subjected to adverse social conditions. Bovet offers only a few weakly stated reservations to this concept. He does not mention the fact that the vast majority of those exposed to poor environmental conditions do not become delinquent.

Again, he writes as if dynamic factors did not operate in those whom he would include under the category of "constitutional psychopaths." Yet elsewhere he himself emphasizes that in every human being biological, psychological, sociological, economic, and other factors are interacting at all times.

He is more mindful of this concept in his chapter on treatment. There he is better able to demonstrate why the rôle of the psychiatrist varies, from that of therapist less frequently, to that of collaborator more often, in the treatment of various types of delinquency.

SAMUEL J. OBERS

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REPORT OF THE GOVERNOR'S STUDY COMMISSION ON THE DEVIATED CRIMINAL SEX OFFENDER. State of Michigan (Hon. G. Mennen Williams, Governor), 1951. 245 p.

What has been called the climate of opinion with respect to the sex offender is well described in this report in these words:

"The sexual criminal feels the focused hostility, contempt, disapproval, and rejection of all society. He can be said to feel this disapproval from more persons and in greater magnitude from all than any other criminal. There is no other criminal type which is so completely deprived of some social acceptance by some congenial group as is the sex offender. We are not including here those men convicted of a homosexual crime, such as being caught in a public toilet with a fellow homosexual. The openly avowed homosexual has a social organization within which to find acceptance, even in prison. So far as other inmates are concerned, he may be very contemptible, and yet there are always others like him who give one another approval. But the sex offenders included in this study are so universally held in contempt that they do not even dare to risk the calling of attention to themselves by forming a 'group of sex criminals.' They are isolated. Most criminals in the prison can take some pride in telling some one of what they were sentenced for. The sex criminal must evade the question or give a false answer. One of the men studied created a sensation in Jackson Prison by being permitted to play the organ for one of the religious denominations in the prison. He was asked to play only in the extremity of there being no other organist available. And he and all the clergymen looked upon the venture as the boldest type of

experiment. As a matter of fact, the experiment did work. But the important fact is that, even in a prison, performance of the rituals relating man to The Prince of Peace is proscribed for the sexual criminal."

What holds for the prison inmates is much truer in the larger community.

In New Testament criticism we learn that certain of the Epistles came into being because specific situations called for their being written. St. Paul wrote to the infant church in Corinth, for example, to deal with some uncomfortable practices disturbing to the peace of the church. The Michigan report grows out of such a situational need. A series of sex crimes, widely publicized, fills the community with alarm. Usually the lurid report of three or four sex offenses touches off an epidemic of crimes of this type. The outraged community immediately becomes panic-stricken, and the legislature responds with the passage of a repressive law. Michigan passed such a law, the so-called "Goodrich Act," which was discovered to be unworkable. The epidemic of sex offenses dies, and the law falls into innocuous desuetude until a new wave of sex offenses outrages the community, and the public clamor demands new harshness against sex offenders.

The commission appointed by Governor Williams to study the problem consisted of four psychiatrists, two psychologists, one sociologist, three clergymen, two judges, one police official, and representatives of mental-hygiene, parent-teacher, and interracial organizations. The commission had an adequate appropriation, and was able to employ competent research staff—individuals whose apparent preparation was in the social sciences.

The heart of the matter is contained in the section, "Summary and Recommendations," with which the report begins. Then follow reports of committees on fact-finding, resources and present practices, legislation, education, and moral and spiritual values. There is a good working bibliography, and the report ends with what might be called a pastoral letter to the parents of Michigan, a dignified, well-considered, and sound document, designed to allay fear and help "eliminate the causes of those incidents which have pained and shamed us."

The commission employed this definition for the purposes of its study: "A person may be considered a sex deviate if his sexual behavior is characterized by repetitive or compulsive acts which indicate a disregard of consequences or the recognized rights of others, or if his sexual behavior indicates an inability to manage or control the sex impulses."

Most of the commission's recommendations are sound. One might quarrel here and there as to detail. For example, it is important that greater care be taken in the handling of the complainant, especially

if the victim of a sexual assault is a female minor. Parents quite rightly fear the repeated recitation of the details of a sordid episode to several sets of police and prosecutors, and the notoriety attendant upon the public trial of the case before a judge and jury, with the fearsome possibility of the presence of reporters in search of sensational "news." The commission advocates the employment of the indeterminate sentence for sex offenders, and recommends that special treatment facilities be established within the state department of corrections, allowing for recourse to the courts by aggrieved individuals who feel themselves unjustly detained. It advocates an educational program to be carried out by school, church, and industrial groups. It advocates the keeping of more and better data on the personalities of school children, which may later be investigated by public authorities if this becomes necessary. It advocates the investment of at least \$50,000 a year for the next five years for a comprehensive research and treatment program. It advocates a degree of voluntary censorship of news relating to sex crimes.

This recommendation seems fraught with some danger. Ideally the publication of the details of sex offenses is something we can forego without any great public loss. Practically the whole question of censorship then comes up for discussion. This reviewer feels quite strongly that the dissemination of news of sex crimes is bad on two counts. It could conceivably encourage weaklings to repeat what has been described in the press. And it certainly stimulates public alarm, which, in many cases, especially in congested slum areas, can start a panic. Yet, as against this, is one old-fashioned liberal's fear of any sort of censorship.

The commission renders unusually fine service to society in laying some of the ghosts that still persist in regard to sex offenders. For example, the commission "uncovered no evidence of a recent increase in sex crimes in Michigan. The reactions of press and public to particularly shocking sex crimes are not accurate indicators of the frequency of such occurrences."

Like many other investigations, the Michigan reports failed to discover the Michigan sex offenders to be oversexed "fiends." More likely they are "unaggressive, timid, and inoffensive." They cannot be cured by castration. Nor do the records show them to be chronic recidivists. As early as 1937, Dr. Henry said that all imprisonment is likely to do is to make the offender more cautious. Nor does the Michigan study gives any evidence that sex offense is an inherited characteristic. Therefore sterilization will not avail to control the reproduction of sex offenders.

The commission well points out that sex offenders take a long time in the making. The need expressing itself in the criminal act did not

arise out of a momentary impulse without any reference to the offender's long history. It is impossible, for instance, to cure in three quick and easy lessons personality difficulties that have been brewing for twenty or thirty years. The process that leads to sex offenses became a reality in the early childhood of the offender. Where? When? How? These are the questions for which research hopes to find some of the answers.

Justifiably the commission advocates more and better mental-hygiene instruction for parents and adults generally. And it says unequivocally that sexual deviation is only part of the problem.

The report offers no panacea. Its findings are marked by conservatism and a sense of the possible. Well does it say:

"At least some of the causes of sex deviation, then, lie deep in the culture, where they are difficult to eliminate, control, or neutralize; just as they have lain in the cultures which preceded this one. The essential difference is that this age knows more and is learning more about the causes of disturbed behavior than previous ages knew. It may some day be possible to speak of solutions. At present it is possible to speak only of alleviations, improvements, and reforms. Within those possibilities Michigan can take, and in the opinion of the Commission is ready to take, some long strides. Present knowledge of the problem, though still at the threshold, will amply support some important and much-needed changes. It is to those changes that the Commission has addressed itself in this Report—soberly, it hopes, avoiding extremes, yet not satisfied with too little."

The commission has amply lived up to what it set out for itself to do. For a state document, its report is a work of unusual excellence. It could easily become, in its field, what the Wickersham Report was and still is in its realm.

ALFRED A. GROSS

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MEDICAL PSYCHOLOGY. By G. K. Yaczynski. New York: The Ronald Press, 1951. 499 p.

This textbook for an introductory course in medical psychology for medical students and students of clinical psychology rests on the broadest theoretical and experimental concepts and constructions. The author states that he had three purposes in mind in selecting the material of the book: the topics had to be of sufficient importance to be included in a brief course in a crowded medical curriculum; a rounded treatment of each topic was to be attempted, the more controversial topics being avoided; and, finally, an integration of the various concepts of the behavioral, Gestalt, and Freudian schools was to be made. To this reviewer, the author has achieved a very

considerable success in his effort, and the criticisms that will be made here of the text are not to be considered as serious.

The book is divided into three parts, the first dealing with basic psychobiological principles, the second with inheritance and maturation, and the third with integration—the structure and structuralization of personality. The material of Part I, dealing with biological needs, emotions, learning, perception, motives, and adjustment to conflicts, presents a broad biological approach to all of these topics, resting essentially on the concepts of homeostasis or balance. The efforts to achieve a satisfactory resolution of disturbances in the homeostasis, due either to internal or to external provocations, turn out to be the adjustment mechanisms and consequences.

The author's presentation of basic psychobiological principles is a far cry from the sometimes cut-and-dried presentation of personality needs and their reduction to "primal" factors—*i.e.*, sexual, aggressive, self-preserved, and so on. The postulate of homeostasis furnishes a neutral concept standing in the background always of the discussion of the mechanisms of adjustment—a neutral concept that demands no parochial adherence and to which any fair-minded person can repair without any feeling of violence to other considerations.

Part II is handled in the same general fashion, with an abundance of material from every school of psychology and particularly from the experimental approaches. Present-day conceptions of the mechanisms of inheritance are thoroughly treated, and methods for the study of inheritance, including the studies of twins in various forms of mental disease, are all well documented.

Physiological maturation is linked with the development of behavioral adaptive mechanisms, with specific attention to the maturation of speech, intelligence, emotions, motives, and social maturity.

Part III starts off with a discussion of the biological substratum of personality, the integration bases, and the physiological substratum in the psychoses and neuroses. Methods for the study of personality include rather extensive accounts of projective methods—the Rorschach, the thematic-apperception tests, the use of questionnaires, and so on. Under the structuralization of the personality, are discussed the interpersonal relationships at various periods of life, the effects of special environments, parental attitudes, anthropological data, and so forth. Each chapter is followed by a rather exhaustive index of the reference material mentioned in the text.

Coming to the end of this text, one can feel that the author has given an eclectic account of current conceptions of personality study, ranging from the strictly physiologic aspects to the most complex psychologic functions, the methods of study, the impressions gained

from these methods, the contributions of the numerous workers in different fields. The readers cannot fail to be impressed by the lack of bias in the presentation and by the thoroughness of the documentation.

Now for the trivial criticisms of the book. The author's effort to fit the discussion of depression and excitement into the homeostasis concepts leads to some simplification that clinical observation would not justify—for instance, his statement that depression is the result of failure in an effort to achieve homeostasis only after a period of excitement; and again his statement that excitements usually present a precipitating cause, whereas immediate precipitating factors are only infrequently found in depression. Actually, I believe clinical observation will show the reverse of this last statement to be more commonly the case. His idea that excitement leads to behavior that reestablishes homeostasis, whereas depression fails to do this, also leaves something to be desired, to judge from clinical observation. Furthermore, his conclusion that the dissipation of depression by any one of the shock therapies is due to the excitement induced by these therapies in the individual would also, I believe, be very difficult to prove, despite his assertion that the adrenal and sympathetic systems are stimulated by all of the shock therapies. I found his discussion of the functions of sleep, and the mechanisms of sleep rather casual, leaving the student of the human functioning very much in the dark concerning some of the simple facts that every one ought to know—for instance, the amount of sleep, the types of sleep, the disturbance of sleep, and so on.

Aside from these minor issues, I feel that this book is to be thoroughly recommended and the author congratulated for his excellent integration of the material of personality functioning, a neutral, but in no sense an emasculated or uninspired, presentation. There is so much material in the book that, as a former teacher of psychobiologic principles, I would find it difficult to see how it could be crowded into most university courses. Nevertheless, the material is here and the high spots can be stressed in lectures and in group discussions.

WENDELL MUNCIE

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SPECIALIZED TECHNIQUES IN PSYCHOTHERAPY. Edited by Gustav Bychowski, M.D., and J. Louise Despert, M.D. New York: Basic Books, 1952. 371 p.

This volume, to which nineteen authors have contributed, depicts a number of different approaches to psychotherapy. The authors of the chapters are psychoanalytically trained, and to that extent the volume may be looked upon as one of psychoanalytic therapy, although as a matter of definition one may not agree strictly with the editors

when they claim as psychoanalytic "every psychotherapy which deals with such basic elements of psychoanalysis as the concepts of the unconscious, transference, and resistance." Some would agree that these concepts are fundamental, at least tacitly, to *all* psychiatry.

Hoch and Polatin lead off with a chapter on narcodiagnosis and narcotherapy, emphasizing the value of these methods as adjuncts in diagnosis and treatment. Lindner then follows with a chapter on hypnotherapy.

Eisenbud discusses the telepathy hypothesis in psychotherapy, pointing out that the ultimate place of psi factors in behavior cannot be evaluated now, but that perspective will develop as time goes on and further observations are made.

Stern presents the use of "free painting" as an aid to individual psychoanalysis. Spotnitz contributes a brief chapter on group therapy as a specialized psychotherapeutic technique; incidentally, he says, the method has advantages in strengthening the social ego of the therapist.

In the field of child psychiatry, we find a chapter by Mittelmann on simultaneous treatment of parents and child; one by Beata Rank on psychoanalytic treatment of children with atypical development; and a case presentation by Despert, illustrative of the treatment of child schizophrenia.

Fromm-Reichmann contributes notes on the development of psychoanalytic treatment of schizophrenics, emphasizing the importance of the therapist's recognizing and controlling his own dissociated feelings and motivations and overcoming his own insecurity. She attributes many failures in the treatment of schizophrenics to shortcomings in this field.

Ruth Fox discusses the psychotherapeutics of alcoholism and the need of an informed public.

Abrahamsen presents some aspects of the treatment of sex offenders, and Melitta Sperling considers psychotherapeutic techniques in psychosomatic medicine. One may, perhaps, be pardoned if her statement that "every case of psychosomatic disorder has its origin in the mother-child relation of dependency," is looked upon as a bit of oversimplification.

There are also chapters by Eisenstein (on border-line states), by Bellak (on emergency psychotherapy of depression) and by Piotrowski and Schreiber (on Rorschach measurement of personality changes). Each chapter is followed by a selected bibliography of recent books and articles.

The volume is a compilation that should be useful to the psychotherapist.

WINFRED OVERHOLSER

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TRAUMA, GROWTH, AND PERSONALITY. By Phyllis Greenacre, M.D.
New York: W. W. Norton and Company, 1952. 328 p.

This is a compilation of papers published by Dr. Greenacre in various psychoanalytic journals between the years 1941 and 1951. There is only one new chapter not previously published. The book is written from the viewpoint of a pure Freudian and both the interpretations of clinical material presented and the theoretical formulations adhere strictly to the Freudian pattern. This implies, of course, no slightest deviation from the complete acceptance of the literal interpretation of the libido theory, with no cultural or symbolic meanings of such terms as penis envy or castration complex.

For one who does not see eye to eye with this point of view, the book is in the main a waste of time. However, for those who are satisfied with this approach to an understanding of the dynamics of behavior, Dr. Greenacre's material will undoubtedly be provocative, since she deals with many areas of common symptomatology—headache, weeping, and urination—and with such common problems as infantile reactions to restraint, predisposition to anxiety, conscience in the psychopath, and the relation of superego development to anatomical structure.

Dr. Greenacre does, however, make at least two specific points that I believe are pertinent, irrespective of the psychodynamic orientation of the therapist. The first is that those patients who have had early physiological traumata chiefly of a neurologic nature not only are particularly predisposed to anxiety and have marked difficulty in their perceptions of reality, with resultant poor ego development, but are not amenable to the ordinary methods of psychoanalysis (and I might add psychotherapy). They require "management" as well as analysis and "the work of the analyst is to increase the immediate reality hold of the patient, . . . defining and clarifying of the immediate conscious attitudes and problems of the patient . . . and interruption of special self-perpetuating autoerotic tension states." . . . It "usually has to be repeated in many different ways through the course of treatment."

The second point is that the time of occurrence of the trauma, whether somatic or psychic, is perhaps of greater import in the matter of symptomatology than the severity or nature of the trauma. Dr. Greenacre sees it as related to the "timetable of the libido" rather than to the total neurological organization of the patient, but does say that "the earlier in life severe traumata occur, the greater are the somatic components of their imprints."

It is my impression that Dr. Greenacre has described fairly accurately at least part of the symptomatology characteristic of organic neurological deficit due to traumata or to hereditary limitations, but it

seems to me she has failed to see the basic somatic or pathologic physiological implications of these traumata and has, instead, worked too hard at shoving the problems into the psychic area. However, one should be grateful to any one who makes real strides toward a delineation of this type of problem.

Again, while disagreeing fundamentally with the author with respect to interpretation, I found myself genuinely appreciating the chapter, *General Problems of Acting Out*. Yet despite characteristically excellent observations of clinical behavior, I felt a lack of credence in, or perhaps even awareness of, purely somatically determined symptomatology.

One additional note may not be amiss. It is clear that despite Dr. Greenacre's many years of clinical work, she has not discarded the practice of making regular notes on her analytic sessions. Consequently she can refer to dates and verbatim quotes again and again. It is a habit well worth retaining.

CAMILLA M. ANDERSON

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THE YEARBOOK OF PSYCHOANALYSIS. Volume 6. Edited by Sandor Lorand, M.D. New York: International Universities Press, 1950. 307 p.

The categories of this volume can be subdivided as follows: The articles of Wittels, Bernfeld, Bergman, and Sterba are centered around Freud's background and the evolution of psychoanalysis, which had its germination in his profound cultural as well as scientific endowment. The scientific basis for his theories is something that has to be brought home again and again, not alone to the lay public, but to his students. It is indeed impressive, because it is beyond the usual continental breadth of most of the learning of the previous century. We can readily appreciate, because of these articles, why Freud took all knowledge as his domain, and why his genius encompassed all aspects of man's creativity, not alone his psychoanalytic contribution. The various contributors to the exposition of Freud's ideas are not only competently equipped as to facts, but write with a clarity that vividly brings home to the reader the genius of the man.

A much needed emphasis in current literature is on the revival of the significance of the dream, upon which Fliess and Lewin focus their interest, with additional articles by Loewenstein, French, and Eisenstein. Fliess's evaluations are temperate, cautious, and extensive. Lewin, as he often does, presents original evaluations, this time of the dream screen.

The high level of the foregoing chapters are continued by Anna Freud's notes on aggression, with her usual succinct, deceptively simple clarifications of complex dynamics. Nacht adds some clinical material to the same theme, while Rosenberg-Zetzel discusses anxiety in a most lucid fashion. The element of sublimation in the grotesque is illustrated by Annie Reich, and laughter in psychoanalysis is investigated by Grotjahn. Hart contributes an encyclopedic exposition of the eye in symptom and symbol. To round out this material are articles by Sperling, on the technique of spacing and crowding emotions; by Jones, on the death of Hamlet's father; by Hitschmann, on Swedenborg; and by Garma, on the origin of symbols in clothes.

We find these annual psychoanalytic compilations amazingly rich in content, nuggets of learning that should be treasured in our libraries.

EDWARD LISS

New York City

READINGS IN GROUP WORK. Edited by Dorothea F. Sullivan. New York: Association Press, 1952. 438 p.

The current state of knowledge in the behavioral sciences and practices periodically demands a cross-sectional collection of "readings" for workers in each corner of the broad human-relations field. The group worker, for example, looks not only to his colleagues in social work, but also to social, clinical, and developmental psychologists, to anthropologists and sociologists, to educators, psychiatrists, and others. Material of interest to any of these specialists appears irregularly in the many publications of all. Since few workers in human relations can keep abreast of all relevant—indeed of all significant—literature, editors of collected "readings" have at least a double task: (1) to consider the publications in each related discipline for their relevance to a given problem area; and (2) to select only the most fruitful writings for an anthology.

For *Readings in Group Work*, Miss Sullivan appears to have performed the first part of this task admirably. Among the twenty-six chapters and the six sections of the appendix, one finds items culled not only from group work's own professional literature, but also from sociological, case-work, psychological, psychiatric, and educational sources. In outline, there appears a nice balance of items concerned with (1) the problems and insights of practice, (2) theoretical issues, and (3) research reporting.

In the first category, Hazel Osborn's paper on resistance in group work (from *The Group*, 1949) is a fruitful contribution, by any standards. In the third category, the Grosser-Polansky-Lippitt report

on an experimental study of the phenomenon of "contagion" (which appeared in *Human Relations*, 1951) is clearly a significant item for a group-work anthology to-day. Wisely, too, Miss Sullivan has included Fritz Redl's "Group Emotion and Leadership" (from *Psychiatry*, 1942), and the Lewin-Lippitt-White "Patterns of Aggressive Behavior in Experimentally Created 'Social Climates'" (from the *Journal of Social Psychology*, 1939). Time has made clear the values of these last two papers, and it is good to have them in a more accessible place than the not always available volumes of journals.

One wishes that time had been allowed to test more of the material selected for this collection. The anthologist, unlike the journal editor, has time on his side. It is difficult to evaluate the fruitfulness of Cattell's recently developed concept of "group syntality" until further research in this framework appears; one wonders, therefore, why group workers should at this time find it in their "readings."

The unrepresentativeness of the recent sociological-anthropological material in this volume is unfortunate. Consideration of the May, 1939, issue of *The American Journal of Sociology* or of papers appearing in *Human Organization* might have helped remedy this deficiency.

Very little in this collection adequately integrates or even reflects the community and cultural factors in group-work practice, notable exceptions being Hazel Osborn's paper (*sup. cit.*) and Nathan E. Cohen's brief discussion of the editor's "x-factor" thesis. Nor, while some of the fragmentary items in this book repeat one another, is there a chapter on the relation of developmental psychology to group behavior. Either Edith Buxbaum's psychoanalytic approach to such material or an academic child psychologist's paper on the development of social behavior could have filled this niche.

Still, if this reviewer is somewhat less enthusiastic about *Readings in Group Work* than, in his jacket blurb, is Charles Hendry (who edited the unpretentious and spirited *A Decade of Group Work* some years back), it is not because Miss Sullivan has, by any means, failed to produce a collection of some lasting interest. In addition to the papers already cited, there are others of value by Saul Bernstein, S. R. Slavson, Gordon Allport, Kurt Lewin; a symposium on research in group work; two pieces by group dynamicists, one by a non-directive-ist; and a too brief item by a psychiatrist.

What is troubling is the unevenness of the collection, perhaps a result of the desire for inclusive coverage without sufficient attention to standards of significance. Until all items prove as promising as at least half of those in this book, such "readings" might more profitably remain thinner volumes. And until the best minds in this field can selectively and inventively weave together, with a clear and pene-

trating value-orientation for group work, the diverse frameworks for practice and research represented in this book, such "readings" will continue to be essential. This is likely to be true for many years to come.

HENRY S. MAAS.

Berkeley, California.

APPLICATIONS OF PSYCHOLOGY. Edited by L. L. Thurstone. New York: Harper and Brothers, 1952. 209 p.

This is a collection of eleven essays in honor of Walter V. Bingham, pioneer in initiating and promoting psychology as an applied science, through whose efforts the first department of applied psychology was organized at the Carnegie Institute of Technology in 1915.

The major group of these essays is concerned with problems in selection. The first is by F. L. Wells, on who should be at Harvard. Succeeding contributions are by Edward K. Strong, on the appraisal of vocational interests; by Marion A. Bills, on interests in selecting men for the life-insurance business; by Edwin A. Lee, on the selection of teachers; by Glen U. Cleeton, on clinical methods in personnel selection; and, finally, there is an appraisal by John M. Stalnaker of a national scholarship program. The remainder of the series is made up of a historical summary by Leonard Ferguson; Thurstone's paper on the problems of studying creative talent experimentally; essays on military applications of psychological principles, by John Flanagan; attitude appraisals in the study of industrial morale, by Bruce V. Moore; and a theoretical paper, by J. P. Guilford, on the appraisal of interests and temperament.

Readers of this journal whose interests do not include problems of selection are not likely to be intellectually enriched by a reading of this book, since the scope of the volume is quite narrow and will probably be a disappointment to those who get it because of the broad view implied by the title.

SIDNEY YUDIN.

Neuropsychiatric Institute, Ann Arbor, Michigan.

NOTES AND COMMENTS

THIRTIETH ANNUAL MEETING OF THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

The Thirtieth Annual Meeting of the American Orthopsychiatric Association was held at the Hotel Statler in Cleveland, Ohio, February 23-25. Some 1,300 persons attended the various sessions.

“Orthopsychiatry and Education” was the theme of the general session that opened the meeting. President Morris Krugman, Assistant Superintendent, Board of Education New York City, took as the subject of the presidential address “Education’s Debt to Orthopsychiatry.” Other speakers at the session were James Marshall, former president of the New York City Board of Education, who spoke on “Children in the Present World Situation”; and Otto Klineberg, Ph.D., of the Department of Psychology, Columbia University, who discussed “Cultural Factors in Personality Adjustment of Children.”

The papers presented at the sessions that followed were classified under a number of general headings—*Sociology, Psychotherapy, International Forum, Orthopsychiatry at the Community Level, Case Workshops*, and so on—and the papers under a given heading were spaced throughout the three days instead of all being grouped together on one day. This arrangement was made, the program explained, in order to permit persons able to attend the convention for only one or two days to attend a variety of types of meeting, instead of being confronted with a full day devoted to only one subject. Also, by offering sessions on the same subject on different days, it helped to solve the dilemma of those who were interested in two subjects presented at sessions that conflicted in time.

Another innovation was the limiting of prepared discussions to one for each manuscript.

There were two audio-visual programs at which selected mental-health films were shown; and at one of the evening meetings a play was presented—*Louder Than Words*, by Eleanor Bayer—which demonstrated the successful handling, through the clinical teamwork of a psychiatrist, a psychologist, and a case-worker, of a tangled-up family situation. This play was originally performed at the Silver Anniversary Meeting of the Cleveland Guidance Center in 1952.

Other special events were a “Dutch Treat” highball party and a dance.

The officers elected for the coming year are: president, Hyman S. Lippman, M.D.; president-elect, Simon H. Tulchin; vice president,

Jean W. MacFarlane, Ph.D.; secretary, Exie E. Welsch, M.D.; and treasurer, William S. Langford, M.D.

The Thirty-first Annual Meeting will be held in the New Yorker Hotel, New York City, February 11-13, 1954.

THE NATIONAL COMMITTEE ON ALCOHOLISM HOLDS ANNUAL MEETING

"What can I do for my alcoholic?" "Where can I go for help?" "How can we all help alcoholics?" were the questions that The National Committee on Alcoholism set out to answer at its 1953 Annual Meeting, held at the Hotel Statler on March 6.

The program included two sessions of papers and discussions and a luncheon meeting. The speakers at the morning session were: Marvin Block, M.D., of the Buffalo Medical School, Chairman of the Erie County Medical Society's Committee on Alcoholism; Robert Fleming, M.D., Director of the Alcohol Clinic of Peter Bent Brigham Hospital, Boston, and a member of the Subcommittee on Alcoholism of the World Health Organization; Arnold Z. Pfeffer, M.D., assistant clinical professor of psychiatry at the New York University School of Medicine and in charge of the New York University Hospital Clinic for Alcoholics; and "J.P.L." of Philadelphia. Dr. Block spoke on "The Doctor Helps"; Dr. Fleming on "The Hospital Helps"; Dr. Pfeffer on "The Clinic Helps"; and J.P.L. on "Alcoholics Anonymous Helps."

The feature of the luncheon meeting was an address by Dr. Norman Vincent Peale, minister of the Marble Collegiate Church, New York City, and author of *A Guide To Confident Living* and *The Power of Positive Thinking*.

At the afternoon session, Mrs. Elizabeth Whitney, Executive Director of the Boston Committee on Alcoholism, spoke on "An Information Center at Work"; Mr. William B. Smathers, Vice President of Rollway Bearing Company, Syracuse, and President of the Onondaga Committee on Alcoholism, on "How a Local Committee Develops"; Mr. Edward L. Parker, Executive Secretary of the Family Service Bureau, Newark, and a member of the Essex County Committee on Alcoholism, on "Other Agencies Help"; the Reverend John Van Dyk, Rector of St. Paul's Episcopal Church, Morris Plains, New Jersey, on "The Church Helps"; and Mrs. Marty Mann, Executive Director of The National Committee on Alcoholism and author of *Primer on Alcoholism*, on "Teamwork."

ANNUAL CONFERENCE OF CHILD STUDY ASSOCIATION OF AMERICA

"Personal Growth and the Pressure to Conform" was the general theme of the 1953 Conference of the Child Study Association of America, held at the Hotel Statler, New York City, on March 2. The

choice of this theme for discussion by a child-study organization was explained on the conference program:

"Family life flourishes best when the temper of society is relatively serene. Undisturbed by constant upheavals, parents and children are given time to learn from one another how best to live in a society based on man's capacity to govern himself. Together they foster respect for the needs of each other and encourage responsible self-discipline. By balancing personal goals with the needs of the group, they are able to move toward mature ways of living.

"But when, as is true to-day, the outside world gets out of balance, the family is in danger of losing its bearings. Its members may veer toward pursuit of self-interest or go too far in yielding to demands for conformity.

"Everywhere we encounter pressures to accept what is generally accepted, to bury our doubts and questions, to leave off learning and growing, and increasingly to give ground to authority. To some extent, people must always subordinate personal interests to the larger aims of the group, but this may bring about a distortion of social values that will tend to destroy individual freedom and creativity.

"This pressure to conform invades our homes to-day. Gradually we are bargaining away our traditional right to choose our own goals and standards and are succumbing too easily to the sanctions and purposes of the crowd.

"How can we maintain our way of life in the face of these dangers? How can parents protect all they most value and still keep alive the spirit of free inquiry and individual independence? How can they nourish their own and their children's aspirations, yet remain realistic? Will they be able to pursue their own generous impulses to take part in vital personal and social issues, despite the pressure to conform?

"These are difficult questions. We believe they can be answered if, as individuals, family members, and citizens, we keep clear the full meaning of responsive and responsible freedom."

At the morning session—on the theme, "The Struggle Toward Personal Integrity"—Buell G. Gallagher, Ph.D., President of the College of the City of New York, and Fritz Redl, Ph.D., professor of social work at Wayne University, Detroit, discussed the threat to human values and social principles in our culture to-day; the effect upon the younger generation of the open conflict between individual freedom and social conformity; and the ways by which parents can gain and maintain their personal integrity.

Leo Bartemeier, M.D., associate professor of psychiatry, Wayne University Medical School, was the speaker at the luncheon session, the subject under consideration being "The Family's Rôle in Personal Growth."

At the afternoon session—on "How Do Parents Learn?"—Jerome D. Frank, M.D., associate professor of psychiatry at Johns Hopkins University, and Nelson N. Foote, Ph.D., Director of the Family Study Center, University of Chicago, took up such questions as: What

knowledge is available to parents to help them in their growth toward mature parenthood? What blocks may affect this learning process? What climate is most favorable to change?

A more extensive discussion of the same subject—how parents learn—was held on March 3 in an all-day conference for workers in parent education.

CONFERENCE ON VOCATIONAL REHABILITATION OF THE MENTALLY ILL

Vocational rehabilitation of the mentally ill is gaining increasing support and coöperation from employers, according to a report issued at the end of a two-week institute for the vocational rehabilitation of the mentally ill, held in January at Teachers College, Columbia University.

Sponsored by the Federal Security Agency, the institute was conducted by the Department of Guidance at Teachers College under a grant from the National Institute of Mental Health. The purpose of the meeting was "to develop an awareness of the value of vocational rehabilitation of neuropsychiatric patients and to enable the institute participants to return to their positions with greater skill and understanding."

The conference was attended by twenty-four state counselors and rehabilitation supervisors from sixteen states and Puerto Rico. The group represented hospitals and vocational-rehabilitation agencies in the New England states, New York, New Jersey, Virginia, West Virginia, North Carolina, Maryland, Delaware, Pennsylvania, Ohio, and Michigan.

"Although research and more knowledge are greatly needed in this field," the group reported, "the vocational rehabilitation of the mentally ill is now a practical reality in many states. This development is an important step in the conservation of human resources so critical in these times of world crisis."

While the trend of coöperation among employers is promising and should be encouraged, the report continued, there is still a need for a "general recognition of the problems of the mentally ill in our society."

To meet this need, the members of the institute urged greater support for "broad programs of public education aimed at removing the stigma attached to this group of citizens."

Emphasizing the importance of conferences of this kind, Dr. Richard H. Williams, an institute participant representing the National Institute of Mental Health, stated that "this institute has done much to assist vocational rehabilitation agencies in the difficult, extensive, and extremely important problems of helping people with emotional difficulties to become adjusted and effective citizens in their communities."

Recommending that similar institutes be offered to all professional members of state vocational-rehabilitation staffs, the participants reported that the two-week conference "has served a basic need for understanding problems and processes of rehabilitation of the mentally ill.

"It has also pointed up the need for a greater exchange of factual information between the psychiatric and occupational-therapy services and community agencies involved in the team approach to the rehabilitation of these people."

The institute was coördinated by Dr. Paul Eiserer, Dr. Charles N. Morris, and Dr. Albert S. Thompson, professors of guidance at Teachers College.

TENTH ANNUAL READING INSTITUTE OF TEMPLE UNIVERSITY

The Temple University Tenth Annual Reading Institute was held in Philadelphia during the week of February 2-6, 1953. The delegates who attended the meetings—classroom teachers, school administrators, psychologists, and vision and reading specialists—represented thirty-five states, Canada, and Norway. This group was one of the largest ever to attend these annual conferences.

Throughout this year's session, emphasis was placed upon basic considerations in the organization of effective reading programs for the development of reading skills in all areas of instruction at every school level. The conference was under the direction of Dr. Emmett A. Betts, of the Temple University Clinic staff, and such visiting lecturers as Dr. Israel Dvorine, of Baltimore, Dr. Daniel Prescott, of the University of Maryland, Dr. William Sheldon, of Syracuse University, and Dr. Paul Witty, of Northwestern University. Under the guidance of these specialists, conferees were trained in practical classroom techniques for the teaching of reading and the correction of reading difficulties. Laboratory sessions were provided to give delegates an opportunity to practice certain of these techniques under the supervision of trained specialists.

Perhaps the most significant single feature of the week's program was the outstanding address delivered by Dr. Paul Witty at the Thursday evening banquet sponsored by the Temple University Chapter of Phi Delta Kappa. Dr. Witty discussed "Some Characteristics of a Balanced Reading Program," and emphasized the need, in a developmental reading program, of specific attention to the fostering of interest in and taste for a wide range of children's literature. He pointed out the value of developing, in those who are preparing to teach, a love of literature that may be transmitted to the children whom they will be meeting in their classrooms.

The Temple University Reading Clinic has announced that

"Differentiated Guidance" will be the theme for the 1954 institute program. This session is scheduled for the week of January 25-29, 1954. A copy of the complete program will be available in November of this year. Those interested in securing advance information about the 1954 program should write to Dr. Emmett A. Betts, The Reading Clinic, Temple University 22, Pennsylvania.

CONFERENCE OF COMMUNITY WELFARE COUNCIL LEADERS

The first Conference of Community Welfare Council Leaders, held in Cleveland, January 8-9, 1953, exceeded expectations in attendance and vitality. Three hundred and sixty-three leaders from 130 communities, more than three-quarters of whom were volunteers, attended and participated enthusiastically in round-table discussions.

Outstanding talks were given by Julian Freeman, of Indianapolis, a business man whose avocation is community service; Governor Lausche, of Ohio; Commissioner Valdo Getting, of Massachusetts; and many others.

At the final luncheon, presided over by Louis Seltzer, conference chairman and editor of the Cleveland *Press*, a demand was made for repeat performances in the future. This brought from the Three C.'s officials present an expression of hope that such a meeting of laymen concerned with year-round community planning might be scheduled every other year, alternating with the C. C. C. biennial convention.

A feature of the conference was the announcement of the 1953 Red Feather Award. It was presented by H. J. Heinz II, C. C. C. president, to Edward L. Ryerson, Chairman of the Board of Inland Steel, long-time leader in Chicago and national community-service activities.

ARKANSAS PSYCHIATRIC TECHNICIANS SECURE LICENSURE

When, on February 25, 1953, Governor Francis Cherry affixed his signature to H. B. #363, Arkansas became the first state in the nation to enact legislation providing for the registration and licensure of psychiatric technicians employed in the treatment and care of the mentally ill. The bill empowers the governor to create a board of psychiatric-technician examiners, and stipulates that it shall be comprised of one psychiatrist, one registered nurse, and four licensed psychiatric technicians who meet certain specific qualifications. This board shall be vested with the sole responsibility of prescribing minimum standards for, and giving accreditation to, schools that offer training for psychiatric technicians; of establishing minimum qualifications for the eligibility of persons seeking such licensure; of formulating and conducting examinations of persons applying for such licensure; of issuing, suspending, and revoking licenses, and issuing

special permits as defined in the bill; and of determining and enforcing such other provisions as are authorized in the bill.

The bill specifies that minimum qualifications for licensure shall include that the applicant be at least twenty-one years of age, a citizen of the United States and a resident of the state of Arkansas, of good moral character, and in good physical and mental health, and shall have acquired a high-school education or the equivalent thereof, and have completed a course of study in an accredited school of psychiatric technicians that offers not less than two years of training. It also includes a definition of the psychiatric technician's function and stipulates who may engage in the practice and use the title.

The bill was introduced by Representative J. A. Gipson, of Saline County, and passed both houses of the legislature by unanimous vote. In presenting his argument for the bill Representative Gipson pointed out that such provision for the services of better trained psychiatric technicians would enable the restoration to health of an increased number of mentally ill patients and their return to a productive place in society. "Such a result," he explained, "will, of course, lighten the tax load formerly required for non-therapeutic, purely custodial care of the mentally ill."

The bill was sponsored by the Arkansas Psychiatric Technicians' Association, organized last fall by graduates of the two-year psychiatric-technician training program which was inaugurated at the Arkansas State Hospital in 1949. Officers of the association are Mrs. Marie Noll, president; Mrs. Della A. Anderson, vice president; and David J. Darma, secretary-treasurer; and its board of directors includes Mrs. Estella R. Brown, Miss Johnnie Finley, Mr. A. J. Noll, and Mrs. Thelma T. Sullivan.

A SCHOOL FOR EMOTIONALLY DISTURBED CHILDREN OPENS IN BROOKLYN

A school for children to whom the doors of public schools are closed has been opened in Brooklyn, N. Y., because of the faith of a handful of parents that successful treatment can be found for one of the most baffling of all diseases.

The school's initial "student body" consists of eight boys and girls, aged six to twelve, all seriously disturbed. Because not too much is known about the educability of such children, the "curriculum" will be flexible. The most definite elements of the experimental school will be an atmosphere of warmth and love and the skill and devotion of specially trained teachers, working under psychiatric guidance. Dr. Grace Abbate will be the psychiatrist.

The eight young pioneers who are launching the school, like thousands of other such youngsters throughout the nation, are among the most unfortunate of all handicapped children. These children are

not mentally retarded—often they are of superior intelligence, with rich artistic and musical talents—but they live in a bewildering world of their own, far apart in mind from all that is around them. They are unable to relate adequately to other people and things. They are uncertain about their own identity and confused in their thinking and feeling about the world outside.

Many of these emotionally ill children cannot speak at all. Those who do use a language that is often retarded or irrational. Their weird gibberish is usually rather an expression of anxiety than a means of communication. Their responses and other behavior are bizarre, usually having little relation to the real world about them.

Psychiatry and psychology, which have made impressive strides in other fields of mental illness, frankly admit that they are stumped by this childhood illness. Some research is now under way, though only a fraction of what is being done in the case of other childhood afflictions. But most scientists fear that at the present rate of research, the discovery of a cause or cure for the strange malady of these disturbed children is still a long way off.

Public schools make no provision for these children, and few institutions, public or private, attempt to treat them. Staff members of the new school are hopeful that they will be able to work out methods for dealing with such children that will eventually be adopted by public schools.

The school will keep close track of changes in the social, emotional, and adaptive behavior of the children. Its findings, it is hoped, will furnish new leads for future research that will advance science's present scant knowledge of this childhood disturbance.

The new center will be operated with the aid and under the guidance of the League for Emotionally Disturbed Children, which, as funds become available, will take over direction of the school and eventually make possible admission of many of the hundreds of similar children in the area who are now untreated.

The league is made up of New York, New Jersey, and Connecticut parents and friends of these disturbed children, with an advisory board of outstanding psychiatrists, psychologists, educators, and social workers.

The league is raising funds to provide partial scholarships for children whose parents cannot afford to pay the full tuition.

The League School is located at 134 Sterling Street, Brooklyn, N. Y.

PATIENTS IN STATE AND COUNTY MENTAL HOSPITALS

The number of patients in state and county mental hospitals has continued to increase, according to preliminary information on the annual census for 1950 compiled by the Public Health Service of the

Federal Security Agency. The census is based on reports submitted to the National Institute of Mental Health by 201 state and 112 county mental hospitals.

A total of about 600,000 persons were under the supervision of these hospitals in the United States at the end of 1950, the census report indicates, as compared with slightly over 580,000 in 1949.

This increase in mental-hospital patients may involve other factors than an increase in the incidence or prevalence of mental illness, as Dr. R. H. Felix, Director of the National Institute of Mental Health, points out. The increase might also be due to growth of the general population, increase in facilities for caring for mental patients, earlier admission of patients through improved diagnostic methods, hospitalization of patients who previously were receiving no treatment, or any combination of these factors.

The average rate of first admissions to public mental hospitals in 1950 was reported as 72.8 per 100,000 estimated civilian population. The rate for all admissions was 97.3. The average rate of discharges from these hospitals per 1,000 patients on the books was 148.5. The death rate was 63.8 per 1,000 patients under treatment during the year.

On any average day in 1950, slightly over 500,000 patients were in residence in these institutions, the report reveals. Thus, for every 1,000 persons in the population, approximately 3.5 were hospitalized on any given day.

The average annual per capita maintenance expenditure for the United States was \$773.43, or \$2.12 per patient per day, and the median expenditure was \$684.07, with a range from a low of \$370.00 to a high of \$1,557.62.

The report is entitled *Patients in Public Hospitals for the Prolonged Care of the Mentally Ill, 1950*, Mental Health Statistics Current Reports, December 1952. Copies may be obtained without charge from the National Institute of Mental Health, Bethesda 14, Maryland.

MICROVOLTMETER AN AID IN DIAGNOSIS OF SCHIZOPHRENIA

The results of a microvoltmeter test are now being used along with other clinical findings to detect schizophrenia, according to a recent report by Dr. Leonard J. Ravitz, associate in psychiatry at Duke University.

"We can definitely diagnose the changing degrees of mental disturbance," Dr. Ravitz declared at a joint meeting of the American Association for the Advancement of Science and the American Psychiatric Association. "The test appears to be to psychiatry and psychology what the sedimentation rate is to tuberculosis."

A specially designed electronic voltmeter which measures the voltage

difference between the head and any other point on or within the body is the key to Dr. Ravitz's recent electronic experiments in psychiatry. His work is based on the fact that each of us, like a battery, gives off electrical waves. Over a four-year period, he has been measuring these "electrical potentials" in insane and normal persons.

"The test helps us pick out the schizophrenics," he explained, "by recording consistent deviations outside the normal range." In a series of 100 cases, he has shown that doctors are able to pick out the emotionally unstable, which may aid greatly in deciding when treatment should begin.

In addition to being a diagnostic aid, Dr. Ravitz said, the test also serves other purposes. For instance, it is a gauge of a patient's improvement, whether it is "spontaneous" or from some form of therapy, such as psychotherapy, carbondioxide, or other somatic treatment. It can be used, too, as a method of gauging changes in the emotional state of a patient. With improvement, the potentials decrease; they rise with an aggravation of symptoms.

Another use of the test is in the follow-up of patients after the completion of their treatment.

The test might serve "as a guide to predicting in a general way periods in which individuals will be least capable of coping with stress and strain," Dr. Ravitz said, and might also make it possible "to detect large masses of emotionally unstable individuals, for example, in the armed forces."

After a personality has been thoroughly studied, according to Dr. Ravitz, one can predict in a general way the most abnormal reactions over a short period of time. These reactions will be based on each person's individual personality make-up.

Every one seems to have similar rises and falls of potential at about the same time, Dr. Ravitz pointed out. This shows that other factors may also be operating which periodically produce general unrest and may set off and heighten emotional disturbances provided these are already present, thus producing an exaggeration of response peculiar to each individual's personality make-up.

There seem to be an almost limitless number of cycles within a twelve-month period, the doctor stated. The most pronounced seem to be the lunar and seasonal variations. Mental illness and emotional disturbances, although due to a complex combination of innumerable factors, appear to have a rhythm. The rhythmic factor, however, makes itself felt only when combined with other causes.

Periodic aggravations of mental symptoms may occur on any day, according to the net effect of all the forces acting upon or within the individual.

AMERICAN ACADEMY OF CHILD PSYCHIATRY ORGANIZED

The new medical society, the American Academy of Child Psychiatry, the preliminary announcement of which appeared in the July, 1952, issue of *MENTAL HYGIENE*, has been formally organized by a group of approximately one hundred child psychiatrists. At a meeting held at the Statler Hotel in Cleveland on February 22, 1953, the following slate of officers was elected: president, George E. Gardner, M.D., Boston, Massachusetts; president-elect, Fred Allen, M.D., Philadelphia; secretary, Frank J. Curran, M.D., Charlottesville, Virginia; treasurer, Mabel Ross, M.D., New York City. Council members are: Edward Liss, M.D., New York City, and Othilda Krug, M.D., Cincinnati, elected for one year; James Cunningham, M.D., Detroit, and Cotter Hirschberg, Topeka, Kansas, elected for two years; and Hyman Lippman, M.D., St. Paul, and Stanislaus Szurek, M.D., San Francisco, elected for three years.

As stated in the preliminary announcement, membership in the academy is limited to physicians who are members of the American Psychiatric Association and who have had at least two years of training in a clinic setting deemed adequate to give training in child psychiatry. A member must have had at least five years of experience in child psychiatry after the completion of his training period. In addition, he must demonstrate, at the time of invitation to membership, that his chief professional interest and activity are in the field of child psychiatry.

COUNCIL ON PSYCHIATRIC AND MENTAL-HEALTH NURSING AUTHORIZED

The following announcement appears in the Winter, 1952-1953, issue of the *National League for Nursing News*:

"It is estimated that 52 per cent of the patients occupying hospital beds in the United States are in hospitals for the mentally ill, but only 3 to 5 per cent of the nurses employed in hospitals are currently working in psychiatric institutions. Some mental hospitals that house several thousand patients have as few as one, two, or three registered nurses on the staff. All in all, there are about 10,000 nurses and 90,000 attendants employed in psychiatric facilities.

"These facts make us realize that much of the nursing care of the mentally ill is in the hands of untrained or partially trained persons receiving no—or at best very little—nursing supervision. Nursing is recognizing the need to remedy this situation and to find ways of meeting its obligations to the mentally ill more adequately than at present. Nursing is also recognizing the importance of doing its share in promoting better mental health.

"As one means of presenting a concerted attack on the problems in psychiatric and mental-health nursing, the Board of Directors of the National League for Nursing has authorized a Council on Psychiatric and

Mental Health Nursing—the first interdivisional council of N.L.N. individual members to be organized. All those interested are invited to join—not only psychiatric and mental-health nurses, but nurses in other fields and persons who are not nurses. There are no extra dues for membership in a council. Simply indicate your interest in becoming a member of the council when you join the National League for Nursing for 1953."

NEW EMPLOYMENT SERVICE AVAILABLE AT NATIONAL CONFERENCE OF SOCIAL WORK

A new employment service for the field of social welfare will be available at the annual meeting of the National Conference of Social Work in Cleveland, May 31-June 5, 1953. A job clearing-house will be set up in the main exhibit hall near the registration counters in the public auditorium. This will be a nation-wide service manned by employment specialists, sponsored by the U. S. Employment Service in coöperation with state employment services, at the request of the National Conference of Social Work and the National Social Welfare Assembly.

All agencies and organizations that seek personnel and that plan to send a representative to Cleveland should file their requests with a local office of the state employment service. Such requests will be sent to the employment headquarters at the annual meeting in Cleveland. Representatives of such agencies who are attending the annual meeting should check in at the employment headquarters as soon as possible on arrival in Cleveland. Agencies that cannot file requests in advance may file them on arrival in Cleveland.

All individuals who are seeking positions and who plan to attend the annual meeting should file applications with their local state employment service in advance if possible. These applications will be sent to the employment headquarters at the annual meeting in Cleveland. If applications cannot be filed in advance they should be filed on arrival in Cleveland. All individual applicants should check in at the employment headquarters as soon as possible after arrival in Cleveland. Only individuals who attend the annual meeting will be served by employment headquarters in Cleveland.

The closing date for the advance filing of job orders and applications in local state employment-service offices is May 15, 1953. After that they must be filed personally at employment headquarters in Cleveland. Employment headquarters will open at the annual meeting at 9:00 A.M. Sunday, May 31, 1953.

Experienced employment-service interviewers will be available at employment headquarters to bring together interested applicants and agency representatives who have listed vacancies. This new service is being set up on an experimental basis. It in no way conflicts with the

interests and services of those national agencies that are now conducting employment services. It is hoped that the new service will assist every one interested in personnel placement.

WORKSHOPS AND COURSES OFFERED

The Institute of Pastoral Care has announced that summer courses of six or twelve weeks in clinical pastoral education are being offered at the following training centers: University Hospital, Ann Arbor, Michigan, Chaplain Supervisor, Malcolm B. Ballinger; Massachusetts General Hospital, Boston, Massachusetts, Chaplain Supervisor, James H. Burns; Miami Valley Hospital, Dayton, Ohio, Chaplain Supervisor, James E. Flinchbaugh; Medfield State Hospital, Medfield, Massachusetts, Chaplain Supervisor, Judson D. Howard; Boston State Hospital, Boston, Chaplain Supervisor, Robert C. Leslie; Tewksbury State Hospital and Infirmary, Tewksbury, Massachusetts, Chaplain Supervisor, Otis A. Maxfield; Emanuel Hospital, Portland, Oregon, Chaplain Supervisor, H. George Randolph; and Worcester State Hospital, Worcester, Massachusetts, Chaplain Supervisor, John I. Smith.

The Institute of Pastoral Care has four primary objectives in its clinical training program:

"1. To enable the student to gain a fuller understanding of people, their deeper motivations and difficulties, their emotional and spiritual strengths and weaknesses.

"2. To help the student discover more effective methods of ministering to individuals and groups and to intensify his awareness of the unique resources, responsibilities, and limitations of the clergy.

"3. To help the student learn to work more co-operatively with representatives of other professions and to utilize community resources which may lead toward more effective living.

"4. To further the knowledge of problems met in pastoral care by providing opportunities for relevant and promising research."

Training programs have been established in institutions that have competent pastoral supervision and contributing professional personnel, and that maintain treatment programs, and more such centers will be opened as these requirements are met.

At each center the chaplain supervisor is in charge of all instruction, assisted by as many qualified associates as the enrollment may require. The ratio is five or six students per leader. Guest lecturers from the institution and its community are invited to participate in the seminars. The programs at the centers vary in content, depending upon the nature of each institution, but all utilize the clinical approach of actual work with people under pastoral supervision, such work being recorded and submitted to the chaplain supervisor and his associates

for constructive evaluation and class instruction. Selected books and articles are assigned for reading and review, and ample opportunity for personal conferences is provided. The daily schedule requires approximately eight hours of attendance at the training center.

All applicants must be enrolled in or alumni of seminaries or other accredited religious training school, or shall have had a minimum of three years of professional religious work or present other similar qualifications. Ordinarily not more than one-third of the total enrollment in any session shall be from one denomination or faith.

Application forms may be secured by writing directly to the chaplain supervisor of the institution in which enrollment is desired. A deposit of \$5.00, which is later applied to the tuition course, must accompany the application. The tuition charge at each center is \$60.00 for a six-weeks and \$120.00 for a twelve-weeks course.

A two weeks' work conference for nurses, on "Current Concepts of Venereal Disease Control," to be held at the University of Pennsylvania School of Nursing in Philadelphia from May 25 through June 6, has been announced by the Public Health Service's Division of Venereal Disease.

The conference is open to nurses and to instructors in schools of nursing throughout the United States and will be conducted by the Pennsylvania School of Nursing, with the coöperation of the Institute for the Study of Venereal Diseases, also of the University of Pennsylvania, and the Public Health Service, Federal Security Agency.

All aspects of venereal-disease control, including diagnosis, treatment, epidemiology, program planning, and administration, will be covered in the schedule. No tuition fee will be required for participation and two credit hours will be granted. All applications should be directed to Miss Theresa Lynch, Dean, School of Nursing, University of Pennsylvania, 3629 Locust Street, Philadelphia 4, Pennsylvania.

Similar work conferences held in other sections of the country during the last few years have been largely attended and enthusiastically received by members of the nursing profession, according to Dr. James K. Shafer, Acting Chief of the Division of Venereal Disease.

Additional conferences at the University of Pennsylvania School of Nursing will be arranged later on during the year to accommodate applicants who, because of enrollment limitations, cannot participate in the course starting in May.

The Second Annual Workshop on Special Education of the Exceptional Child will be held at the Catholic University of America, from June 12 to 23.

Catholic educators are concerned about the large increase in the

number of handicapped children seeking admission to parochial schools. Teachers are being trained and plans are being made to accommodate some of the 12.4 per cent of the school population who are either physically or mentally handicapped.

Lectures, discussions, and seminars will be held on the mentally retarded, the cerebral palsied, the deaf and hard of hearing, the blind and partially seeing, the socially maladjusted, the speech defective, the undervitalized, the gifted, and on remedial reading, occupational therapy, tests and measurements, guidance, and arts and crafts.

After the workshop there will be a summer course for teachers of the blind and the partially seeing from June 29 to August 8. Reverend William F. Jenks, C.S.S.R., is in charge of the special-education programs at the Catholic University.

Based upon seven years of pioneering research and experience in the relatively new field of training leaders in the skills and understandings necessary for developing effective groups, the National Training Laboratory in Group Development will hold its usual three-week summer laboratory session at Gould Academy, Bethel, Maine. The dates will be from June 21 through July 11.

Approximately 110 applicants will be accepted for this session. Persons involved in problems of working with groups in a training, consultant, or leadership capacity in any field are invited to apply.

The purpose of the training program is to sensitize leaders in all fields to the existence and nature of the dynamic forces operating in the small group and to help them gain skill in operating more effectively in such a group. The training program is organized so that each trainee group of from 15 to 20 persons is enabled to use its own experience as a laboratory example of group development. Group skills of analysis and leadership are practiced through the use of rôle-playing and observer techniques. Concentrated clinics give training in the skills of the consultant and the trainer in human-relations skills. There is also opportunity to explore the rôle of the group in the larger social environment in which it exists. Finally, a major portion of the last week of the laboratory is spent in specific planning and practicing the application of laboratory learning to back-home jobs.

The laboratory research program in group behavior and training methods is an important part of the training, and the use of research tools that are within the range of the laboratory training program is incorporated into the curriculum.

The National Training Laboratory in Group Development is sponsored by the Division of Adult Education Service of the National Education Association and by the Research Center for Group Dynamics of the University of Michigan, with the coöperation of faculty members

from the universities of Chicago, Illinois, California, Ohio State, Antioch College, Teachers College at Columbia University, and other educational institutions. Its year-round research and consultation program is supported by a grant from the Carnegie Corporation of New York. For further information, write to the National Training Laboratory in Group Development, 1201 Sixteenth Street, N.W., Washington 6, D.C.

Through the coöperation of several graduate departments, the University of Minnesota Summer Session will present a Family Life Workshop in the summer of 1953. The purpose of the workshop is to offer a synthesis of advanced practice at the graduate level for those now professionally engaged in family-life education—teachers, marriage counselors, social workers, public-health workers, research personnel, and others in the family life field.

Members of the leadership team are: Henry Bowman, professor of family life, Stephens College; Ralph Bridgman, Chief Marriage Counselor and Supervisor of Marriage Counseling, Court of Domestic Relations, Lucas County, Toledo, Ohio; Reuben Hill, research professor in family life, Institute for Research in Social Science, University of North Carolina; and Lester Kirkendall, associate professor of family life, School of Home Economics, Oregon State College.

The content of the workshop is being organized around four study areas—teaching, marriage counseling, research and evaluation, and community education and planning.

The workshop dates are July 6-24 inclusive. The university offers four quarter credits for those who wish graduate credit.

For further information write Mrs. Dorothy T. Dyer, Chairman, Family Life Program, 204 T.N.M., University of Minnesota, Minneapolis 14, Minnesota.

The Institute of General Semantics will hold its Tenth Summer Seminar-Workshop at Bard College, Annandale-on-Hudson, New York, August 15-30, 1953. An optimal post-session will be held from August 31 to September 3.

The workshop will offer intensive training in the theory and techniques of Alfred Korzybski's non-Aristotelian discipline as formulated in *Science and Sanity*, *Manhood of Humanity*, and so on. It will include a fundamental course for developing competence in the methodology of general semantics—for teaching, research, writing, etc.—and basic preparation in the application of the methods to problems of evaluation and communication in the sciences and arts, education, medicine, law, and other professions, business and industry, and personal living.

Admission requirements are flexible and scholarships are available. Teachers, research and other professional workers, university students, and former seminar registrants are eligible for a 50 per cent reduction in tuition charges. Early registration is requested as enrollment is limited. For application forms and further information, write Registrar, Institute of General Semantics, Lakeville, Connecticut.

ANNOUNCEMENTS OF MEETINGS

The National Council on Family Relations will hold its annual conference at the Kellogg Center for Continuing Education, East Lansing, Michigan, September 1-3, 1953. Further information may be obtained by writing to the National Council on Family Relations, 5757 South Drexel Avenue, Chicago 37, Illinois.

The 18th International Psycho-Analytical Congress will take place in London, at Bedford College, Regents Park, July 26-30, 1953.

CURRENT PUBLICATIONS

The Proceedings of the Fourth International Congress on Mental Health, held in Mexico City, December, 1951, have just been published in English and Spanish. The English edition is now available from the Columbia University Press, 2960 Broadway, New York 27, N. Y. The price is \$5.00 per copy.

Dr. Alfonso Millan, chairman of the program committee of the congress, has generously agreed to contribute the proceeds from the sale of the English edition to the World Federation for Mental Health.

How seemingly small, unresolved family difficulties eventually add up to multi-million-dollar burdens upon American communities, is stressed in an illustrated pamphlet, *The High Cost of Unhappy Living*, recently published by the Family Service Association of America, in coöperation with the United Community Defense Services.

In an appeal for early prevention of family troubles through the extension and strengthening of social-case-work services, the pamphlet describes the results of family unhappiness in everyday, human terms. It sees an enormous challenge to every community in such facts as these: death, desertion, disease, and divorce have left one-fifth of the children in the average American community fatherless; mental ill health is costing federal and state governments more than \$1,000,000,000 a year. Other huge social costs, springing largely from unresolved family problems, are represented by the million juvenile offenders apprehended by police each year and the often unnecessarily high turnover in jobs. Of the latter, Dr. William Menninger, internationally known psychiatrist, says: "Many surveys show

that 60 to 80 per cent of all dismissals in industry are due to social incompetence and only 20 to 40 per cent to technical incompetence."

Many families are able to work out personal problems without outside help and some family difficulties are almost impossible to prevent. *The High Cost of Unhappy Living*, however, presents stories of typical family breakdown to show that professional social-case-work services can often help to prevent personal failure and family disharmony, with tangible savings in community costs. The family worries of a machine operator, Henry Borich, for example, were responsible for the accident at the stamping mill that mangled his arm, shut down a section of a defense plant for half a day, and cost the public an estimated \$2,400 for hospitalization and financial assistance to the family over a period of six months. In contrast, a family case-worker was able to help the Cardwells repair a tottering marriage before any of the by-products of domestic bitterness—delinquency, divorce, desertion, or institutional care—were created. The cost of the counseling and prevention in this case was \$450 against the thousands such problems often ultimately cost the taxpayer.

Furthermore, family troubles cannot be measured in dollars alone, Clark W. Blackburn, General Director of the Family Service Association of America, points out.

"Besides the immediate personal suffering, the disruption of family life is likely to carry into the future the seeds of personal unhappiness," he says. "Children from a disorganized family tend to become poor parents and are less likely to become responsible citizens."

The High Cost of Unhappy Living, is directed primarily to leaders in communities, particularly defense areas, where social-case-work services are not yet organized. It explains the origin and functioning of family-service agencies already existing in hundreds of communities throughout the country. The facts it offers make it of interest to any one concerned with the prevention of family failure.

Single copies of the pamphlet can be obtained from the Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. at 25¢ per copy. As a participating member of the United Community Defense Services, the association offers special help in bringing case-work services to defense-affected communities.

A 30-page booklet, with the title, *The Child Entering Nursery School, A Study of Intake Principles and Procedures*, by Dr. Joseph Steinert, Ph.D., Mrs. Edith Atkins, M.D., and Mrs. Theresa Jackson, M.S., has been brought out by the Council for Child Development Center, 227 E. 59th St., New York, N. Y., at a price of 50¢ a copy.

The purpose of the study is to make the important transition from the shelter of his home to the new world of the nursery school a mean-

ingful and happy one for the child. It provides no pat formula, but it does represent the distillation of the experiences of the Nursery Consultation Unit of the Council for Child Development Center during a three-year study of nursery schools and the way they handled "one critical phase of nursery school experience—the beginning."

The center's consultation team, made up of psychiatrist, psychologist, social worker, pediatrician, and teacher, recognized that "entering nursery school is one of the first big steps for the young child in growing up. Whether he takes this step with eager anticipation or with anxiety and dread will depend upon the child's previous experiences, including the way in which he has been prepared for nursery school . . . and the way in which intake is handled by the school."

Entrance into nursery school means that "the care, education and social conditioning of the child are to be shared now by parents and teachers. This poses a challenge for every one concerned. At intake, the initial manifestations of this event are crystallized in the interaction between child, parent, and school." The team believes that "the gains in understanding the child, his needs and his potentialities that can be achieved during intake should lead to a more constructive nursery-school experience than would otherwise be possible."

The study high-lights the "emotional, psychological and educational dynamics inherent in the intake process," starting with the first contact between parent and school. In tracing the steps by which the child got to nursery school on that red-letter day of his entrance, the team considers the application for his admission and how it was handled by school and parent; the first interview with the parent; follow-up talks, if any; the child's pre-admission visit and what provisions were made for his observation at the time. Even the child whose application is rejected is considered in the study, for rejection, too, has its effect upon all concerned, as the team notes. In short, the application process must be viewed as a balancing of the needs of the child, his family, and the school community itself.

Once the application interview indicates that the child will probably fit into the nursery school, intake interviews should be scheduled, the center's team advises, "not to obtain a mass of information, but rather to gather only such pertinent data as will help prepare the school for the child's entrance . . . it should be relevant to those situations in the nursery school he will be expected to meet."

Family diet, sleep habits, sibling relationships, parental attitudes, all should have a bearing on the child's handling during his first days at nursery school. The study includes case histories to illustrate its recommendations in specific situations. Similarly, it considers at length the possibility of home visits during the intake study period, the pre-entrance visit of the child, and the adjustment period after admitt-

tance, including separation from the mother and possible mother-teacher collaboration.

Of particular interest to nursery-school directors and board members is the discussion of the rôles of the various members of the nursery-school staff in the intake process, from director, teacher, and social worker to nurse, pediatrician, child psychologist, and child psychiatrist, where indicated.

At the request of the Special Juvenile Delinquency Project of the Children's Bureau of the Federal Security Agency, a committee of the National Social Welfare Assembly has prepared a short report or statement on the relationship of the police to social agencies in dealing with juvenile delinquents. This statement has been issued in pamphlet form under the title, *Juvenile Delinquency and the Relationship of the Police to Social Agencies*. Pointing out that in the effort to cope with juvenile delinquency, the police and the social agencies have had to enter into a relationship for which both require preparation, the statement goes on to discuss what the social agencies—administrators and workers—need to know and to do in order to make their partnership with their local police effective.

Copies of the pamphlet are available at the office of the National Social Welfare Assembly, 1790 Broadway, New York 19, N. Y., at 15¢ a copy, or 12¢ apiece for five copies or more.

MENTAL HYGIENE

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EDITORIAL

MENTAL HYGIENE has in the past been guided by a set of principles designed to give its readers as much aid as possible in exercising their mental-health leadership:

1. The magazine is addressed to the mental-health leadership with the intent of providing them with a scientifically sound journal to aid them in their work.
2. It is, therefore, conceived within the framework of a number of disciplines that are concerned with matters of effective psychological functioning. These include practitioners such as the teacher, the doctor, the social worker, the clinical psychologist, the nurse, the public-health worker, the clergyman, mental-health association executives and board members, and others. It also includes teachers of these professions.
3. It rarely publishes highly technical articles, considering these more appropriate for the scientific journals of the specialists, but it does attempt to cross disciplinary lines, taking the experience of the special field and translating it to the whole.

Has MENTAL HYGIENE served your needs? If so, tell us how, in order that we may be more aware of the positives and strengthen them. If it has not, tell us in what way it can be made to serve you better. If you have any other suggestions as to format, content, or concept, we would appreciate a letter from you on these points.

HIGHER EDUCATION AND MENTAL HEALTH *

GEORGE E. GARDNER, PH.D., M.D.

*Director, Judge Baker Guidance Center; Lecturer, Department of Social Relations,
Harvard University*

I CONSIDER it my first duty—and indeed the most pleasant of the duties incumbent upon me this evening—to congratulate you of the graduating class, who are to receive your degrees from this university as its first group of graduates “*in honoris causa*”—honored for outstanding proficiency and attainments in scholarship.

I presume that by this time you of the present graduating class are rather well accustomed to the many and varied “firsts” that have been accorded you in this comparatively young—but already famous—university. But surely none of these “firsts” can outweigh in importance, in the self-estimation of each of you—and in the evaluations of those who join you in this brief ceremony of congratulation—the “first” that you have won in intellectual potential, application, and the results of both.

I do congratulate you as members of the Brandeis Honor Society, and I believe it is quite in keeping with expected future developments to hail you as the probable nuclear initial group that will one day be recognized as the Brandeis University Chapter of Phi Beta Kappa.

In as much as I am certain that this is the future course of your society, upon receiving the invitation to speak to your group, I turned for inspiration and guidance to the most famous of all Phi Beta Kappa addresses—that of Ralph Waldo Emerson to the Harvard College Chapter one hundred and fifteen years ago, entitled *The American Scholar*, a speech that has been termed by Oliver Wendell Holmes “our intellectual declaration of independence.” And in this search I was not disappointed. For it seems to me that if you were to combine the attitudes and principles—and the exhortations—

* Presented before the Brandeis Honor Society, Brandeis University, Waltham, Massachusetts, June 14, 1952.

of Emerson, in this accolade of the scholar as "Man Thinking," with those expounded in his speech on "Man the Reformer," delivered three and a half years later, you would have in this combination about all that one could wish as a formula for socially useful and mentally healthful living.

It is perhaps because Emerson's terminology is old, and because his concepts lack the stream-line and stratospheric quality of those of our latter-day medico-social sciences, that I, a psychiatrist, am invited to speak to you upon the topic, "Higher Education and Mental Health." But there is, it seems to me, an even deeper and more significant meaning to such an invitation. It is a further indication and added evidence that we in this century have become increasingly aware that "man thinking"—though indeed the attribute of the true scholar—is not *total* man, or even perhaps the most important aspect of man. In addition we have come to the fateful conclusion that "man feeling" and "man acting"—that is, acting principally upon these feelings—is of equal, if not of greater, importance to us in modern society, both for ourselves in our own individual lives and for men acting together as groups, as nations, or as combinations of nations.

It is the mental health—the emotional health—of man that concerns us more and more, and we look for principles and formulas that will assure us an even chance for the establishment and maintenance of individual and societal sanity, that each and all may live and work constructively.

Unfortunately we in the medical field do not have, even yet, a completely satisfactory definition of mental health. But we do have some notions as to what mental health is not! Above all, mental health is not the mere absence of mental disease; rather, it includes the discrete elements and the sum total of any individual's responses to the other people who comprise his immediate world. And of equal importance, we know that mental health is not a static condition of good adjustment which, when once attained, is forever retained. As Whitehead said of the "imaginative life," the mentally healthy life "cannot be acquired once and for all and then kept indefinitely in an icebox to be produced periodically in stated quantities."¹

¹ See *The Aims of Education*, by Alfred North Whitehead. New York: The Macmillan Company, 1929. p. 102.

Mental health is a process—or, better, it is a task—that is presented to us day after day in a never-ending series of situations—situations involving ourselves and other individuals—that demand instant, subtle, and satisfactory solutions. And in the central position and as the nuclear essence of these situations are our deepest instinctual drives and the feelings or emotions attendant upon them.

The most general thing we can say about mental health, then, is that it is the resultant of—or perhaps it is better to say the best possible bargain or compromise that we can get between—those innate driving forces that are the basic sources of energy for all our acts and the like demands of those about us. And the compromise must be both satisfying to us and at the same time considered satisfactory by others. A lack in either respect designates an act as not mentally healthful or perhaps, if wide enough of the mark, as definitely deviant.

If such is the case, it is then clear that one rôle of the institution of higher learning is that of potential contributor to the present and future mental health of students who study therein. In addition to the inculcation of conceptual tools for living, it does or should contribute to the emotional adjustment of young men and women immediately in its presence—particularly in the matter of some of the specific and well-known problems that inevitably confront individuals of the college-student age level—and also it should go far in establishing principles for effective living that will make continuing adjustment easier thereafter. That in some instances, as you are aware, it seems to do neither, in nowise reduces the inherent obligation that it should.

What are some of the mental-health tasks that are set for the student of college age—that have been set for you in your years at this university—to the solution of which higher learning should have contributed greatly? These are not problems that are set *by* the university—and particularly they are not problems that only students fortunate enough to get into college face; they are universal problems of development—of personality development, if you will—that all must face and all must solve. Our present discussion relates only to the partial—and in some instances only temporary—contributions that I hope your college has made in your own individual endeavors to solve these problems. I should add,

too, that they are not the problems or conflicts that publicly shriek for solution; rather, they are those that are part and parcel of the dogged and unspectacular fight for growth toward emotional maturity that confronts us all.

1. Of primary importance in the search for emotional maturity is the establishment of a realistic concept of one's *self*—one's abilities and one's potentialities—together with the establishment of a realistic appraisal of the responses to be expected from other human beings. By the acquirement of a realistic concept of the self and others, I mean the modification of one's infantile and early-life notion either of omniscience and omnipotence or its extreme opposite, the child's conviction of helplessness and ignorance.

Quite contrary to the popular notion that higher education augments or even creates these infantile fantasies of egocentric importance and of ego-centered wisdom, the company of scholars of all ages that comprise the university should go far to modify both. And, by the same token, this reevaluation that is so necessary for personality growth—and to which the company of scholars, both colleagues and teachers, necessarily contributes—should not lead to a reactivation of former feelings of inferiority or to the torture that self-doubt and self-depreciation always bring. With a fuller realization of the accomplishments of true scholarship, armed with many of the facts and methods of scholarship, and cognizant, too, of the present-day limitations and shortcomings of both, the student should be enabled to view himself and his world, now and later, with an enlightened and realistic appraisal. From the psychiatrist's point of view, this is an extremely important aspect of the mental-health process and one of its perennial tasks. And at no time in life is this struggle more poignant than at the college-student age level.

2. A second and closely related mental-health task in these years is the modification of one's feelings toward parental figures—toward one's father and mother. I need not emphasize with you—and particularly I need not emphasize with your parents—that an adolescent youth (I've tried religiously in this talk to leave out this word "adolescent," but we are here talking of *early* adolescent youth) seemingly must take his initial steps toward independence and emancipation by a process of first devaluing father and mother and renouncing

much in the way of ideas, ideals, loyalties, and values that the parent has tried to instill from earliest years.

This devaluation may come early in adolescence, but come it will sooner or later, and it usually prostrates the parents of the adolescent for the time being. If they can just stand such punishment for a few years, they will be rewarded by their return to favor in the eyes of the youth when the latter has acquired a more realistic estimation of their value.

In regard to this aspect of personality growth, my thesis is again that the institution of higher learning assists in the solution of this second mental-health task. For in the light of the markedly extended and intensive knowledge of hard-won ideals and values of the ages that are emphasized and reemphasized in the university, the parents and their values usually do not come off so badly by comparison. The parent may not have had the words by which—or the name of the philosophical system or rubric under which—these social, moral, or ethical principles are subsumed, but it is not unusual for the student consciously or unconsciously to recognize more than coincidental similarity. At that point the student's parent-estimates change, and they change in the direction of realism and maturity. Youth-parent relationships change for the better, but of even greater significance, the youth has completed another step in personality growth.

3. There is, however, one aspect of growth at this time of life that is, paradoxically enough, a rebirth of a faith in a type of thought of inestimable value that is characteristic of the mental functioning of childhood. I refer here to intuitive thinking and specifically to a re-trust in your own generalizations and formulations. The creative curiosity, free interpretations, and associations allied with innermost feelings, needs, and fantasies that constitute the joyous aspects of learning in infancy and early childhood are later subjugated and depreciated by the necessity for acquiring the so-called "hard facts and figures" of this world. And in many instances they are lost forever.

Presumably it is not solely through a university education that a reawakening of these creative potentials of the personality is accomplished, nor does it always happen even in a university. Yet I am sure that even the dullest of us, under the impact of our associations with creative scholars and

the creative contributions of past centuries, have ourselves experienced from time to time the elation that accompanies our own rediscovery or our own reformulation of a scientific fact or plausible and sensible theoretical construct.

It is of little import that it may be later demonstrated to you that this is a *rediscovery*. For *you* it was independent and creative thought, and from it you may take the deep satisfaction that at one time a "student thinking" stood at this selfsame point in his development as you yourself stood—equipped with the knowledge of your own moment—and he created anew.

If your university, through the excellence of its teaching, affords to you a series of such independent rediscoveries, there is reborn within you a childlike trust in your own intuitions, a reexperience of the joy that inevitably accompanies them, and the determination to follow them to creative fulfillment. As far as I know, this is the only instance in which a regressivelike maneuver of man is distinctly a step forward in development. This maneuver, I submit, does constitute an element in personality growth and is in itself a thrust toward maturity.

4. In the fourth place, it is also apparent that it is through such experiences as these that the student may solve the problem of the choice of his future occupation. And in the interest of his mental health—to say nothing of his future existence—it is necessary that he make a definite choice and make it wisely. You will note that I do not say that the student must obtain an exact and correct clarification in his own mind as to *why* he settles upon a certain vocation to the exclusion of all others, and I am sure that his studies in the university will not afford him that clarity of motivation that all of us like to think we have—or that at least we think we should have.

For example, I doubt if the geologist ever knows exactly why he became a geologist, or the physician why he chose to be a physician; nor would he necessarily be a better geologist or a better physician if he did. The motives of both are buried deep in the instinctual needs of each as modified by earlier critical and crucial life experiences.

This is true of all men. The tragedies accompanying "the-round-peg-in-the-square-hole" situation are usually brought

about not because the individual cannot really and completely know the subtle elements in his motivations toward a particular vocational choice; rather, they are due to a non-exposure to a needed host of endeavors and interests among which one—and preponderantly this one and not that one—will beckon him with an undeniable insistence as the one best way of securing a maximum of expression of his deepest needs.

No single institution in our society—and certainly no vocational or educational guidance system that has been devised up to this moment—can match the university, with its programs of liberal arts and general education, in offering this so necessary wide exposure of media for continuing and satisfying self-expression throughout life. If the institution of higher learning does not perform this rôle, it misses one of its greatest opportunities to further the future mental health of the students who come to it.

5. I should add to this needed identification with an occupational rôle (and I assure you I do not give it a parenthetical unimportance) the strengthening of your identification of your rôle as a member of one sex and your functions and duties as a future husband or wife and as a future parent that are allied to this rôle. That exact and sufficient medical information—or in most instances *reeducation*—relative to the biological facts inherent in this rôle is necessary, goes without saying. But from the mental-health standpoint, the data and insights relating to the larger problems, conflicts, and satisfactions attendant upon your assumption of these rôles are equally important. One does not become a total man or a total woman through the force of biology alone; he or she becomes such only with the acceptance of—and a sophistication in—the crucial subtleties in those interpersonal relationships that these rôles demand. It is to be hoped that higher education does assist in preparation for these tasks that will comprise so large a factor in later emotional adjustment.

6. And finally, I shall comment upon what appear to me to be man's greatest triumphs—though triumphs not yet completely won—his control of his instinctual aggressive drives and the substitution for them of impulses that you and I may designate as idealistic, or at least constructive. This is the supreme task in man's search for mental health. It is universal; it is never-ending. University training of leaders

and the results of university-inspired research in social relations will be the greatest factors in determining the outcome of this struggle both on the individual level and in respect to organizations of men.

Contrary to what you might expect, the ingredients of idealism in their broadest sense constitute the very essence and core of the psychiatrist's affairs. The problem of values—which surely is an analogue of the theologian's spirit or ideal—is the problem confronting the psychiatrist at every turn. Regardless of his school of professional allegiance and regardless of his therapeutic approach, value judgments are the entities or the processes to which he listens, as given to him by his patients day after day.

And if you should ask him for a summation of what he hears and his estimation and evaluation of it as it concerns man's values, you would note an interesting paradox relative to his clinical findings, on the one hand, and *his own feelings* about man, on the other. Both aspects of this paradox or the contradiction of data and feelings have, I feel, an important bearing on our hopes for youth, based on a maintenance of a worthwhile, but realistic idealism as an earnest of mental health.

On the one hand, the medico-social scientist is acutely conscious—and made so by endless repetition—of the fact that the central and nuclear impulsions of man are his destructive and aggressive tendencies. He notes them at all levels of organic life and he traces them through their myriad ramifications in all the social relationships of man. The forms of destruction are at one time mutilative and attacking, at another osmotic and seductive. Man holds, as it were, a naked dagger in his hand and he holds it by the blade. There is no handle. If he slashes his neighbor, he himself is cut. For seemingly the laws that govern this behavioral process are just as inexorable and inevitable as are those of mechanics that cause the push of the blade to cut in both directions.

These are the findings. You would expect, then, that the psychiatrist would be discouraged or depressed, or at least pessimistic and cynical, or, worse, that he even might run from his consulting room with the shout, "*Destrudo omnia est*"—"All is destruction." But such is not the case. I am an optimistic psychiatrist, and I am quite convinced that many of my colleagues are also avowed optimists. I am optimistic

about man and I am particularly optimistic about the youth of the present and of the future. But I assure you it is a realistic and not a blind optimism.

What are the bases for this apparent paradox, this seeming contradiction in my clinical findings, and particularly in my evaluative feelings, that lead to a consoling sense of optimism about man and youth?

The real basis for my optimism is that I feel that men and women—both as individuals and living together in groups—are at last not afraid to recognize man, including themselves, as he is, with all his destructive tendencies, and are seriously endeavoring to do something about him in as careful and as practical a manner as the present state of our knowledge about human behavior will admit. It seems to me that our fundamental hypotheses and our assumptions about man today are more realistic and more exact than ever before, as we attempt to design individual life programs or local and worldwide experiments.

On all sides we note growing evidence that more individuals than ever before, as well as more societies, ethnic groups, and nations—and groups of united nations—are well aware of the fact that the central problem of individuals and groups of individuals living together is the problem of control of individual and group hostility and aggression. To return to my analogy, it is as if groups or nations of people, too, had at last shared intuitively, and almost concomitantly, the clinical notion that they, too, are holding a handleless sword by the blade.

Individuals *sometimes* and nations *always* have paid a terrible price in happiness and efficiency before acting upon these insights, derived from the repeated confrontation with and the accurate interpretation of such data. But they are acting upon them, and we most decidedly are on our way to the establishment of individual and social programs for effective living.

But what is the meaning of all this in terms of the mental-health resources of man and particularly the idealism of youth? Every theologian will agree with me, I believe, when I say that youth is in danger of losing its idealism at just that chronological age—the college age—when it becomes increasingly aware of this expressed (and, of equal importance, this

unexpressed) self-seeking hostility and aggression that they note in others and in themselves. It is a particularly unsatisfying revelation of inner impulses and an unsatisfactory observation of others whom they have used as models.

This cynicism is in large part due to the protective tendency that youth embraces—that, in fact, all of us embrace too often—to project onto others our own undesired insights concerning our own behavior. Youth declares: "If I have such impulses, all others must have the same—and there is no idealism in any of us!" Every youth to some degree, I might say, and at some time reaches just this point at which you would have expected my psychiatrist to run screaming from his clinic.

But we can expect 90 per cent of young people to pass through this stage of cynicism—not entirely unscarred, I will agree, but they *do* pass through it—and to regain a degree of idealism and enough spirituality to enable them to live efficient, mentally healthy, and worth-while lives. Some of them live dedicated lives. What brings this about? What enables them ultimately to see purpose and value as ingredients of living? It is in the furtherance of this process that the university plays an important rôle.

Surely it does not result from their denial of the realities of their own inner instinctual drives and those of others. Nor does it arise from a dictated and superimposed conviction that this is the best of all possible worlds. On the contrary—in these generations of turmoil and strife—it arises first of all from a realistic *acceptance* of the basic impulses of man and, secondly, from a realistic *evaluation* of the intrinsic potentialities for good as well as for evil in these basic human tendencies.

For in spite of the presence of models of human behavior that are detestable which we may see on all sides, there are also models of human behavior that are admirable in that they direct their hostility and aggression toward evil and against all individual and social ills. These are the models for identification which youth—and all of us—need and crave as our only solution for our own inner conflicts. The life programs of such models offer the paradigms for the needed socially acceptable expression of our own impulses. These models exist in the scholars in the universities who are dedi-

cated to their tasks, and they exist in abundance in the lives and accomplishments of the hundreds of scholars, living and dead, who become known to you indirectly through their imperishable contributions to the progress of man.

Sooner or later in all people comes the unexpressed conviction that if one is destined to struggle—that if the primary biological pattern of one's expressed energy is the pattern of conflict—a certain proportion of this energy may well be invested in a struggle for some *social* good. It is at just this point that the youth becomes an idealist, but with an idealism shorn of the fantasies of earlier childhood, an idealism that *reinvests* with interest, concern, and value his interpersonal relationships within his family and his society. This is the "secondary idealism" of mature adulthood as distinguished from the "primary infantile idealism" embodied in the wishes of the young child. And I submit that however small is the part a man plays in this dedicated struggle against social ills—in the rôle of citizen, parent, or at his work or profession—just so far is he an idealist, and we must never depreciate his contribution. And a society may well be judged as good or bad to the extent that it offers to man—and to youth particularly—the right and the social instruments to carry out this worth-while aggressive activity.

These, then, in conclusion, are some of the various tasks involved in the pursuit of a mentally healthy state. And in again offering to you newly elected members of the Honor Society my sincerest congratulations, it is my hope that the higher education which you have received has contributed, and will continue to contribute, to your effective and satisfying solution of these tasks.

THE MULATTO CHILDREN IN GERMANY

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THE word "mulatto"—not often used in the German language before—has in recent years become a generally understood term. It refers particularly to the children who are the offspring of German women and colored soldiers of the occupation armies. With the exception of a few members of French and Dutch colonial military units, the fathers of these children are American Negroes.

The begetting of illegitimate children has always been a concomitant of war and military occupation. According to an authoritative statement made at the session of the German parliament (*Bundestag*) on April 7, 1952, 94,000 so-called "occupation babies" were counted in the territory of the West German Federal Republic (comprising the United States, British, and French occupation zones) and West Berlin. Out of this number, 3,093 are children of mixed—that is, white and colored—parentage.

How have these children fared so far, what is their present situation, what does the future hold for them? To those who shrug off any such questions with an unconcerned reference to the relatively small number of the so-called mulatto children (compared with the total child population of Germany, or even the total of illegitimate births in that country), a German magazine article replies: "One should not express tragedy in numbers." Is there tragedy in this problem? Moreover, is there a problem?

In order to appraise the surrounding factors, it is necessary to remember that only a handful of non-white people ever lived in Central Europe and in Germany in particular. To the average German, tensions between white and black, racial strife, and restrictive legislation based upon racial differences of Caucasians, Negroes, and Orientals, were little-known items in newspaper reports from foreign countries. There

was, on the other hand, even before Hitler, a widespread feeling among Germans of their own racial superiority. Who were considered to be inferior, depended upon the political exigencies of the moment: the Frenchmen, the Poles, the Italians, the Jews, the natives in the African colonies, Negroes, members of the "yellow" race were intermittently looked down upon. Valiant efforts were made during the time of the Weimar Republic to instill in the young Germans the idea of world brotherhood and racial equality. After Hitler's rise to power, an orgy of race prejudice and discrimination, race hatred, and finally mass murder based on race (now defined as "genocide") ensued. It seemed significant that the infamous anti-Semitic Nuremberg laws put "Jews" and "colored" in juxtaposition.

Naturally, after twelve years of the most vicious propaganda of race superiority by the Nazi régime, many concerned people wondered what the attitude of the Germans toward the little Negro children would be. These youngsters would probably have three strikes against them. Not only are they illegitimate, but they are the fruit of illicit relations between a German woman and a member of an army that had conquered Germany. (Would people remember that many women were prompted to enter into such liaisons by hunger, despair, and loneliness in those post-war years of utter destruction and defeat?) In addition, the mulatto child—the mixture of two racial strains—shows his illegitimacy and his "foreignness" in his features.

Has the apprehension of interested individuals in Germany and abroad and of national and international child-welfare bodies been justified? The following observations are based on some American publications, on the study of numerous articles in German newspapers and professional journals, and on interviews which the writer had with social-service experts in various cities of Germany during his trip to Europe in the summer of 1952.

Where do the mulatto children live? According to a survey made early in 1952, a total of 1,941 (or 62.8 per cent) are living with their mothers, and 388 (or 12.5 per cent) with the mothers' families, mostly the maternal grandparents; of the remainder, 450 (or 14.5 per cent) are taken care of in foster

homes, and 314 (or 10.2 per cent) are placed in group care, orphanages, or other children's institutions of public and private social agencies. While the totals of local figures vary according to the stationing of American Negro troops, especially in the first years after the war, the statistical breakdown as to whether the children are with the mothers, the maternal families, in foster homes, or in institutions, is quite constant, as reports from such cities as West Berlin, Frankfurt-on-Main, Munich, and Nuremberg indicate.

The fact that over 75 per cent of these children are living with their mothers or maternal relatives is hailed as a healthy sign by German child-welfare experts. A press release of the "*Deutscher Verein für öffentliche und private Fürsorge*" (the German Association for Public and Private Social Welfare, a highly respected central research agency) of August, 1952, states, on the basis of numerous case reports received by this organization over a period of several years, that, with very few exceptions, "these children who are living with their mothers and maternal relatives are cared for with special affection and warmth. Actually they are often given preference over their white siblings. In situations where the birth of such a child had originally led to friction between the mother and her parents or other relatives, the difficulties suddenly disappeared when the grandparents or other relatives met these children for the first time. There are even cases in which husbands of these mothers, after their return from foreign countries, where they had been held as prisoners of war, accepted the mulatto child and are treating him the same way as their own offspring. Reports from nursery schools indicate that these children are in no way rejected by the other children."

The report admits that, although infrequently, people meeting these children occasionally—for instance, in public transportation vehicles—speak in derogatory terms about them. It is assumed, however, that these remarks are directed rather against the mothers than the children. Only in rare instances did other parents object to the presence of the mulatto children in the kindergartens attended by their own children.

Such individual incidents cannot mar the optimistic over-all picture. The reason for the somewhat unexpected general

acceptance of these children, by relatives, friends, and strangers alike, seems to lie in the personality of the children themselves. Not only do they possess appealing features, but almost all are normal or even superior intellectually and emotionally. Their perceptivity is good; they are outgoing, good-natured, and ready to help; they are full of tenderness, have a great amount of vitality, and a vivacious temperament.

It is true that the majority of the mothers live in rather poor economic circumstances, and the question has been raised as to the possible harmful effects of these conditions upon the children. But, the survey stresses, there is no justification for the removal of these children from their homes because, as has already been pointed out, they enjoy loving care and warmth in their surroundings, and their mothers have no wish to part from them. The report, however, recommends that the public authorities give supplementary financial assistance wherever it is needed.

The children who are cared for in orphanages or other institutions live under the same conditions as the other children placed there. No difficulties have been reported. In the majority these are children who are rejected by their mothers. One might ask whether German families could be found willing to receive children in their homes. Actually there exists a small number of such families, who—not on the basis of a paid foster-home relationship, but because of a profound human feeling of responsibility—have accepted a child of this kind into their midst. (Reference will be made later to such a case history.) This number, however, is bound to remain small.

From a legal standpoint, the status of these children is not different from that of other illegitimate children, so far as the matter of guardianship is concerned. According to a comprehensive German law on Youth Welfare in 1922, the county or city child-welfare department automatically assumes official guardianship over every illegitimate child at the moment of his birth. The guardianship may later be transferred to an individual, in many instances to the natural mother, if it is in the interest of the child. One of the main purposes of the official guardianship is to protect the child's legal claim to support from his father.

In this respect, however, the situation of the German illegitimate children of American soldiers is quite precarious. The substantive law pertaining to illegitimacy in Germany varies from that in the different states in the U.S.A.; even more so, the court procedure for the establishment of paternity is fundamentally different in the two countries. Quite aside from that, the legal status of a member of the occupation force is "extra-territorial"—i.e., he is not subject to German civil and criminal law. This will be changed once the Contractual Agreement which has been drawn up in lieu of a peace treaty with Germany (which cannot be achieved because of the intransigent attitude of the Russians) becomes effective. At the time of this writing, it had been ratified by the United States, Great Britain, and Germany, but not yet by France. It contains a provision that will make the individual members of the armed forces of the three Western Powers stationed in Germany subject to German law (i.e., to criminal law, with certain modifications, and to non-criminal or civil law without limitations) and German judicial procedure. The claim of an illegitimate child in Germany to support is governed by German civil law. It remains doubtful, of course, whether any such claims that might be filed in the future under the provisions of the Contractual Agreement will have retroactive effect.

An additional difficulty arises from the fact that the soldier-fathers of these children frequently are moved around and can no longer be located. This was especially true in the case of the fathers of children begotten in the first few weeks or months after the war's end in 1945. Meanwhile, many of the fathers have been discharged from the armed forces and returned to their home land. In general, there are at present the greatest difficulties in obtaining support payments for these children. The International Union for Child Welfare in Geneva recently called the attention of the United Nations to this problem; whereupon the secretary general requested the U.N. Committee of Jurists, which is charged with preparing a Convention on Obligation to Support Abandoned Dependents, to take up the matter of the illegitimate children fathered by members of military occupation forces.

There are, naturally, some cases in which the soldier-father

acknowledged paternity and subsequently has contributed toward the support of his child. From various sources it is reported that the fathers of the mulatto children are generally more interested in their children than the fathers of white occupation babies. In the great majority of cases, however, the burden of support for these children falls upon the mother and her family, and if the mother is unable to carry it or the child is placed in foster or institutional care, upon the German public-welfare authorities.

The chances of legitimization through subsequent marriage of the mother and the father are much smaller for the children of mixed parentage than for the white children. There are, first, a number of legal impediments arising from the prohibition, in some states of the U.S.A., of mixed marriages. The necessary permission by commanding officers to marry is much more difficult to obtain—if not impossible—in cases of Negro would-be husbands. There are also social and psychological obstacles. Many a mother rejects the marriage proposal by the Negro father of her child because she is reluctant to live in a community that is not only located in a foreign country, but in which—because of her own racial difference—she expects (rightly or wrongly) never to be fully accepted.

On the matter of adoption—whether by German families or by American couples—some comments will be made later in this paper.

Six years being the lower compulsory school age in Germany, the oldest of the mulatto children were admitted to public school on Easter, 1952. The number of this group is estimated as between 600 and 700. The approach of the day of their entering school caused a considerable number of articles to be written dealing with the problem of their integration into the general school population. In at least one city, Bremen (located in an enclave of the U.S. Zone), it led to a proposal to enroll these children in separate schools, but happily this plan was not carried out. Several departments of public education in the various West-German states (*Länder*) issued instructions in favor of complete integration. For instance, the Minister for Cultural Affairs of the Land North Rhine-Westphalia, in his decree to the local school authorities, stated:

"I am confident that the attitude of the teachers to this problem will be guided by the conviction that these [Negro] children are the equals of all their schoolmates and that they need the special inconspicuous attention of their teachers. Beginning on the first day of school, the feeling of self-understood fellowship among all children should be cultivated. The danger of group-selfishness must be fought. The school's efforts, of course, can only be successful if they are supported by the parents of the pupils. It is, therefore, recommended that wherever Negro children will enter school on Easter, 1952, this problem be carefully and thoroughly discussed with all parents."

The Bavarian Minister for Public Instruction and Culture referred in his decree (which is almost identical with the one cited above) to the brochure, *Maxi, Our Negro Lad (Maxi, unser Negerbub*, published by Eilers and Schünemann, Bremen, Germany), which was written by a high-school teacher, Alfons Simon, under the sponsorship of the German Conference of Christians and Jews. This organization was founded a few years ago to further interracial understanding in post-Hitler Germany; it works through more than a dozen local chapters, each with a board of directors, consisting of a Protestant, a Catholic, and a Jewish member. The liberal-minded president of the West German Federal Republic, Dr. Theodor Heuss, has been keenly interested in its activities. It seems significant that this group considered its program of inter-group relations as all-inclusive and, therefore, sponsored and promoted the brochure dealing with the acceptance of a little Negro boy in a German public school.

The booklet is full of pictures of beautiful white and Negro children; the cover shows Maxi, a most appealing and intelligent-looking boy. The text is directly addressed to the first-grade teacher, Mr. Schmidt, of a public school in a large city where, for the first time, a Negro boy is to be enrolled. Compared with the previously cited report of the German Association for Public and Private Social Welfare, the story is less optimistic with regard to the public attitude toward these children. It, therefore, deals with the origin of the prejudices of Germans against the natives in their former colonies, against the foreignness of the performers of weird African

dances at county fairs and in circuses, and in general, against everything that is "black" as tantamount to "bad."

It describes how the teacher, who is trying hard (and in the end successfully) to overcome his own prejudice, visits Maxi's foster mother a few days before school opens. "Maxi was an unwanted child," she tells him; his mother knew even before he was born that she could never marry his father. Her own family disowned her. After the child's birth in a hospital he was immediately taken to an orphanage. She had to pay for him, but could not keep him with her since she had to work. "Thus Maxi became our foster child. . . . But people are so unreasonable. Wherever I am with the child—on the street, on the playground or in the streetcar—everywhere he is stared at and fussed about: 'Oh! how sweet, how charming!' . . . , or there are looks and remarks full of rejection. How can a child stand this? . . . Children are much more sensible than grown-ups. Look down in the yard: all four children who live in this house play together. I am worried over one thing, however, and I heard this, too, from other mothers of these children: he gives in too easily whenever children ask him for something; he is too generous and too good-natured. In later life, these characteristics may easily prompt people to exploit and misuse him."

Then the child enters the room to meet his teacher for the first time. "There is so much natural softness in the movements of this dainty child with his big, dark eyes and his black tousle-haired head," the teacher notices.

The story goes on to relate how Mr. Schmidt familiarizes himself with literature on prejudice and its effect; how, after the school term has started, he uses the announcement of one of his pupils about the arrival of a little baby brother at home for a talk on babies in all parts of the world, including Eskimo babies, Negro babies, Indian babies. Magazine pictures show the pupils how differently babies of these races look and how differently they are brought up.

"But one thing is the same all over the earth," Teacher Schmidt concludes. "All mothers love their children."

There are talks with other teachers, a discussion at a parent-teacher meeting, an appeal to third-grade students, some of whom had called Maxi names: "Too bad that Maxi does not

go to third grade. You would realize he is a fine lad just like you, and the only difference is his darker hair and darker skin. He talks Bavarian just like you, he reads, does arithmetic, and writes just as well as the other children in my class. Maybe, on your way to or from school, you talk to him. We are happy that beside the many children with light skin and blond hair, there also is a darker boy in our school."

This rather detailed excerpt is included here because this 45-page brochure is an earnest, unsentimental, human contribution to the understanding of the little Negro child in Germany.

Articles in magazines of the Catholic and Protestant women's organizations dealt most constructively and realistically with the integration of these children in the public schools. *Die Katholische Frau (The Catholic Woman)* of May, 1952, pointed out that the basis for the relationship to the mulatto children should not be "what is commonly called sympathy, especially when the proverbial talent of persons of mixed parentage becomes apparent that makes them sometimes excel over their classmates. The emotional climate they need is not sentimental sympathy, but understanding and lasting love." In *Jugendwohl*, a Catholic magazine for child care and youth welfare (1952, first issue), an article on the same subject closed with these words: "We should be aware that the fate of the mulatto children in Germany will show whether our faith is still a living reality and a life-giving power." Similarly, the president of the German Protestant Women's Federation, at a recent conference of educators, emphasized that "to care for the illegitimate children of colored occupation troops in Germany is a human, ethical, and religious responsibility of the German people."

How one family translated this responsibility into reality is told in an article, *Our Brown Brother*, by Erich Lissner, a German journalist, in the magazine, *Wir Alle* (No. 39, 1952). "In the year 1946," he reports, "my wife heard one day from the midwife in a maternity clinic that a refugee woman was expecting a child from an unknown father, a colored soldier. . . . After we had survived the war unharmed, we considered it an act of gratitude, almost a mission, to adopt this child. . . . With the permission of the Municipal Child

Welfare Department, we took the little brown child home from the clinic. We already had four boys of our own. They were enthusiastic over the prospect and could hardly wait for his coming. They adorned the baby carriage with flowers, in order to bring Donatus home in a festive way. Yes, we named him, 'Donatus,' the 'Given One,' but we call him 'Doni.'

"On the day of his arrival, his room was decorated, a candle was lighted, my wife sat at the piano, and the four white brothers greeted Doni with a beautiful children's song containing these lines: 'God in Heaven loves all children. He knows you too, and loves you, too.' That should become Doni's life's motto.

"He is now six years old, a schoolboy, a healthy child, a bright lad, physically well developed and full of vigor. He is very graceful in his movements. He can laugh most heartily, but he may also succumb uninhibitedly to his sorrow. . . .

"Again and again, we are being asked about his personality. He is exceedingly good-natured, tender, very eager to help, sometimes reticent, polite to strangers. . . . Between him, his four little brothers and his little sister who came after him, there never was a difference or strangeness. He gets along well with the children in the neighborhood. Because he is a good playmate, he is liked by every one; they call for him and he is often invited. None of the children in the neighborhood reject him. If they had ever ridiculed him, he would have told us. . . .

"It was more difficult with the adults. In the beginning they were quite opposed to the whole idea. Many acted in a very snobbish manner, indulged in gossip, and were morally indignant. Some tried to talk us out of it; my wife ought to think of her reputation. And there were whispers about heredity, of the different 'blood' that eventually would come to the fore. But on the other hand, there were sensible people right from the beginning who understood us and approved our action. Others, who formerly shrugged their shoulders, and looked quite suspiciously upon our experiment, now love the child. To-day, Doni has many friends among the adults.

"We have always endeavored to keep him free from any inferiority complex. We told him that God created brown, white, and yellow people and that he is our dear little

Negro. Therefore, at the last Mardi Gras, when children run around in costumes, he joyfully exclaimed: 'I'll be a Negro. I am well off. Other children have to buy themselves masks.' . . . When on Christmas a nativity play was prepared, he himself volunteered to be Balthazar, the black one of the Three Wise Men."

Concluding his story, Mr. Lissner says, "We just have to have the courage to treat and educate these brown children as equals of the white children. One day, they will earn their living with us and among us. After all, we do not want to think that somebody again might appear who will 'solve these problems' with deportations, gas chambers, and similar methods. We are responsible for these children and it will depend upon our attitudes whether they will become asocial and fail, or will succeed in life."

Obviously there are not too many examples of such profound conviction and determined courage that lead to the adoption of mulatto children by German families. Some children were adopted by American Negro soldiers and officers stationed in Germany and their wives. Still others were adopted by Negro couples in the U.S.A.

No general recommendation can be made as to what is best for these children. Prejudices exist in Germany as well as in the United States, just as good will exists in both countries. Constructive advice can be given only on a case-by-case basis. Some child-welfare workers in Germany, with whom I discussed this question, favor adoption on a large scale by American Negro couples; it is obvious that these social workers deal primarily with those of the mulatto children who are not wanted by their own mothers, and who are, therefore, cared for by public-welfare authorities in orphanages or foster homes. For them, adoption—if not possible in Germany, then by American couples—might be the best solution. On the other hand, I heard many social workers and other interested people in Germany emphasize that these children should remain the responsibility of the German people, and that their acceptance into the community will be the best proof to the world that the German people have at last rid themselves of the terrible scourge of racial hatred, prejudice, and feelings of superiority.

Although the picture of the mulatto children's fate in Germany, as shown in this paper, is not always too clear and in some respects is ambivalent, it can, in general, be stated that the more optimistic outlook seems to be justified. Walter White, Executive Secretary of the National Association for the Advancement of Colored People, in a recent newspaper column on the occupation babies in Germany and Japan, observed: "It is significant that two nations which have recently undergone violent indoctrination in racism appear to have recovered from the virus of racial supremacy to a greater extent than some sections of the United States."

To this writer, it seems that the majority of the mulatto children will remain in Germany. This would call for an improvement of their legal rights, especially their claims of support from their fathers, on an international basis of child protection for all war babies. Psychologically, it would require continued adult education among the German people so that these individuals of mixed parentage will not be accepted only as long as they are "cute" children in nurseries and grade schools, but in the years to come as equal members of the community, participating in the cultural, social, and economic life of that nation.

A valuable help in this direction might be provided by a recently released German film, *Toxi*, in which a real mulatto child who was adopted by East German refugees, now residing in Bavaria, plays the main rôle. This motion picture depicts the development of understanding by her neighbors for the little Negro girl, while the German children never take any notice of her color.

German and American social workers, educators, and child psychologists alike should continue to watch the growth of these children, their difficulties, and their adjustments. Their healthy development, it is hoped, will be proof that the world—notwithstanding the darkness of our times—is yet on the road to human brotherhood.

THE FOURTH CATEGORY OF PERSONALITY NEEDS

A CRITICAL ANALYSIS OF A PSYCHO-THEOLOGICAL PROBLEM *

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IT has long been recognized, both by psychiatry and by psychology, that the human personality possesses three categories of basic "needs," which in turn give rise to their respective drives and motivations. These groups are generally agreed upon as, first, the *biological* or organic, consisting of such needs as hunger, thirst, sex satisfaction, maternal fulfillment, and so on; second, the *psychological* or "personal" category, with its needs for freedom to think, feel, and act as we wish, for personal security, and so on; and third, the *social*—in terms of "how we appear to others"—with such needs as gregariousness, the need to be loved, thought worthy, respected, admired, and others of similar character.

It is quite true that there have been many important modifications among experts from time to time in such matters as the number and types of needs that should be ascribed to each category and, what is more significant, there have been differences of opinion as to the origins of the various needs. For instance, the technical view at one time that most of the psychological and social needs were innate and even hereditary—as held by most of the "instinct" psychologists—has more recently given way to the more scientifically tenable view that *only* the biological needs may be correctly considered as both hereditary and universal; that the other two groups are definitely the resultants of man's cultural environment. Both sociology and cultural anthropology have definitely confirmed this view on the basis of overwhelming evidence, and it is now generally accepted.

* This article is a revision of a paper read before the Psychology Division of the Virginia Academy of Science on May 16, 1952, at Old Point Comfort, Virginia. The views expressed in this article are those of the author, and do not necessarily coincide with the views of other members of the hospital staff.

We now propose a fourth category of personality needs—in reality a single need—which we shall designate simply as the *spiritual* need. At the outset, it should be made quite clear that we do not refer to any one limited set of tenets, or any special dogma constituting a particular “religion”; rather, we refer to the almost universally *acquired* need which, in times of overwhelming strain and stress in life, forces man to seek immediate aid from some superhuman power in the universe, whether he may think of it as a *personalized* Divine Being, designated “God,” “Jehovah,” “Allah,” “Buddha,” or what not, on the one hand; or merely as some kind of *impersonal*, but superhuman “Force,” on the other. To man, however, the practical aspect, at such times of serious emergency, is whether he can obtain the needed assistance, and how speedily.

Now, as is well known, whenever there is a more or less serious conflict between the early and deeply laid principles of the social and psychological needs, on the one hand, and transgressions of such principles, on the other, we find some form and degree of personality disorder resulting. (Here it should be mentioned that rarely do biological conflicts produce serious disorders in man—with the occasional exceptions of the sexual and maternal—whereas experimental psychology shows that they frequently do so in the case of animals—*e.g.*, the experimentally produced “neuroses” caused by conflicts over biological deprivations.) Likewise, when the deeply laid religious principles are transgressed or thwarted, man usually develops more or less serious personality conflicts, with their inevitable accompanying increase in tension. Such conflicts may be just as, or even more, profound than those due to purely secular frustrations. In such cases one might rightly say that man becomes literally “sick in the spirit.”

It is true that psychiatry has already taken heed of such a universal need in man and, accordingly, has developed a special branch of theory and practice to deal with it and related problems. We refer to the field of *pastoral psychiatry*. Incidentally, we find to-day that many priests, ministers, and rabbis are being provided with training in this field to supplement their theological education. Psychology, on the contrary, having long prided itself—possibly with false pride—on its strictly scientific and secular interests and activities,

has consistently avoided the issue, contending that the problems of the spirit lie outside the realm of scientific investigation.

In the case of experimental psychology, this may still be largely true. Clinical psychology, however, in recent years has been forced to take cognizance at least of the very obvious fact that man's personality includes that highly important, complex division known as *character*, much of whose *raison d'être* derives from man's relationship with some exalted power lying outside himself. Moreover, even clinical psychology has observed that when such a relationship, early acquired and strongly rooted in the depths of man's personality in infancy and childhood, is either lost or seriously disturbed in later life, there results more or less profound conflict in his life, manifesting itself in some form and degree of personality disorder. Such unfortunate individuals are often found to be quite difficult to deal with therapeutically.

How may one identify the individuals with this serious malady of the spirit? It is necessary at this point to exclude two disordered groups, many of whose members are confined in mental hospitals, and who might erroneously be considered by the layman to belong in this category. First, we refer to the religious paranoiacs who have become "unbalanced" on religious matters. One might superficially say of these psychotics that they had received an overdose of religion, but such an explanation would not be strictly true even in their case. Their actual condition is that, being full of religious faith and zeal, they have lost correct perspectives and have developed a wrong sense of values in life, so that their personality disorder manifests different degrees of distorted thinking, with or without unbalanced emotionality, as the case may be. These people are indeed ill—some even incurably so—but they are not the unfortunates to whom we refer.

The second excluded group comprises certain depressed, potentially suicidal patients who believe that they have committed the so-called "unpardonable sin," or have done some other monstrous thing which they believe has put them beyond the pale of religious hope, both of which constitute forms of delusion. Fortunately, such cases are frequently of only temporary duration, completely disappearing after proper therapy. Such psychotic patients rarely include any of those to

whom we refer; the rare exceptions will usually be found to be those individuals who have developed this latter psychotic pattern because of prolonged *voluntary* violations of spiritual laws.

The authentically spiritually ill, soon to be described, show rather, in a vast majority of cases, a *neurotic* pattern of extreme severity. They may be thought of as falling into two groups, which actually differ in degree rather than in type of illness. In the first group are to be found those individuals who, although retaining some religious feeling throughout their lives, have more or less seriously violated the moral and spiritual principles of their faith from time to time. Each time this occurred, some degree of conflict resulted, with accompanying feelings of guilt and remorse.

As previously mentioned, since these religious principles and values had been instilled early and firmly within the developing personalities of those individuals, the resulting illness was often profound. Both theologically and psychologically, the fact that guilt and remorse are still present in such cases is considered a very favorable sign, giving promise of a good prognosis, since these emotions may rightly be regarded as indicating the presence of "insight" in the patient. And insight, as is well known, is almost indispensable to the cure of all psychogenic, or purely functional, personality disorders.

The second group consists of those individuals who, although they once had some variety of satisfying religious faith in their youth, have lost their priceless possession somewhere along life's way and, consequently, constitute a group of the most miserable of human beings. They are easily recognized as those men and women—rarely are they found in their early years, but usually in the middle and latter decades of life—who have gone through life continually seeking one thrill after another, vainly trying to make life seem worth living.

Outwardly, they often appear even exuberant, but on closer examination such effervescence is found to be hollow and superficial, producing a false gayety and light-heartedness. They frequently make exaggerated claims of possessing the most superior intelligence; they display ultra-sophistication, and become increasingly blasé regarding everything in life; they scorn all influences that have any religious flavor, and scoff on all occasions vociferously at the simple, satisfying

faith of others. They have sabotaged the most profound source of personality peace and contentment earlier in life. For them, life has lost its zest, and the living of life its meaning and purpose; for them, the end of life signifies stark, hopeless death—the end!

Let us, however, analyze this second group psychologically. In their vaunting boasts of superior intelligence—i.e., superior to that of all who retain some type of religious faith—they *delude themselves*; by actual psychological test they are found to fall along the well-known normal curve of I.Q. distribution, with perhaps fewer cases among the feeble-minded for the obvious reason that such defectives are unable to think abstractly. On the other hand, far fewer are found in the upper brackets also, comparing favorably in intelligence with the world's Pasteurs, Carrels, Pupins, Millikans, Comptons, and a countless host of others, both living and dead, who retained their religious faith *despite* possessing the highest order of intelligence, as manifested by their world-renowned achievements both in theoretical and in applied fields.

Therefore, in considering the delusion of our second group, we note the first of their pathological symptoms—i.e., their error lies in their false belief that they possess very superior intelligence. The truth of the matter is that their mental power—whether superior, mediocre, or inferior in any particular case—is distorted in its functioning, and their views are immature and sophomoric.

We, as educators, are quite familiar with the adolescent "intellectual" who, in the joyous thrill of first using his blossoming intelligence on higher abstract matters, delights in sipping the forbidden wine of agnosticism and atheism. Rarely, however, are these immature youths serious; more often they merely enjoy shocking their elders. But, even if a few actually be sincere, we do well to refrain from becoming unduly alarmed, for we know that with the approach of intellectual maturity and sounder experience in life, these youths will "put away childish things" and think as mature men. Unfortunately, however, our deluded ones of the second group in many instances remain immature and sophomoric throughout life.

• Their second pathological symptom is not so serious in nature: it is the very familiar neurotic behavior dynamism

known as *overcompensation*. As we recall, our unfortunates tend to scorn all matters spiritual, and to scoff at the religious faith of normal, healthy individuals. Such behavior clearly indicates their more or less conscious realization of having lost something priceless that others still possess. As in most such cases of overcompensation, which is a recognized attempt at protecting and bolstering the ego, there is also frequently some actual jealousy present. In short, such individuals hope to deceive others into believing them both superior in intellectual ability and most highly enlightened, but, unfortunately, they often have subconscious misgivings about themselves; in many cases they deceive no one but themselves. It is this that is most poignant in their case.

In these more serious cases of spiritual illness, is the prognosis hopeless? In the majority we would think not. As in our first group, where the presence of guilt and remorse augurs well, here also there is some hope in the fact that insight, although not fully conscious, does lie just below the threshold. In fact, some eventually show partial recovery, others complete recovery, without the aid of therapy. The former may effect a compromise with their conscience by aligning themselves with some religious faith that is more of an ethical than a theological system, as if grudgingly affirming a belief in a Supreme Being, but no more! The latter subgroup may return to the religious faith of their youth, or even unite with a religious faith that is more completely theological, as if, psychologically, to make more thorough amends for their previous defection. It is strongly to be suspected that these latter resolve their profound conflicts and release their pent-up personality tensions more completely—and thereby regain a much fuller measure of spiritual tranquility—than do the former.

As for others who do not manifest such unaided recovery, we believe proper psychotherapeutic procedures would be able to strengthen and elevate existing insight into full consciousness. When this is accomplished, then the other symptom, a form of delusion—which we believe is not nearly so fixed and systematized as that found in pure paranoia—would in most cases begin to wane and finally disappear, thus leading to complete and possibly permanent recovery.

Naturally, there will be found some totally resistant cases as when, for instance, the "self-delusion of intellectual gran-

deur" is more definitely fixed, or more likely, in those cases in which there is merely a complete absence of religious feeling. Such individuals may be completely hopeless. Probably many of these are to be found in the constitutional-psychopathy class, wherein the individual may be completely impervious to any kind of therapy, including religious appeal. Such would most likely not display the cardinal symptoms mentioned above, but would go more or less serenely on their way through life, quite satisfied with their faithless condition. (Theologically interpreted in the Christian tradition, they would technically be considered as "lacking the presence of the Holy Spirit.") In such cases, however, it is doubtful whether they *ever* had any appreciable degree of religious feeling in their youth. Such hopeless cases, therefore, would lie outside our special category of the spiritually ill.

In conclusion, we believe that there is entirely sufficient evidence, both from clinical findings and from general observations, to support our claim that this fourth category of personality needs does exist; and that this category comprises one single, highly important need—the spiritual, which involves some form of religious faith, whether in a personalized Divine Being or in an impersonal Supreme Power.

Furthermore, as psychiatry has recognized this need and dealt with its disorders therapeutically, so clinical psychology should also freely admit its existence as a natural personality phenomenon, and treat its deficiencies and distortions as recognized clinical entities. Since, therefore, modern psychotherapy treats the whole "psychobiological" man, if this need be an integral part of man's personality—as, in view of the evidence, we believe that it definitely is—then clinical psychology cannot afford to ignore this part in its attempts to reintegrate the personality of man into its normal, healthy, totally integrated form.

In the attainment of such a goal, it should be obvious that theology and the modern sciences of personality fully collaborate and complement each other, thus working constructively for man's present and future benefit. When clinical psychology shall have recognized and assumed its new responsibility, then time and progress alone will determine whether even experimental psychology may not also play its rôle in this highly important field of endeavor.

A PARENT-EDUCATION PROGRAM IN A VOCATIONAL-GUIDANCE AGENCY

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IN January of 1949, the Jewish Vocational Service of Milwaukee initiated a parent-education project through group discussion. The project was financed by B'nai B'rith, which supports the group guidance program of the Jewish Vocational Service, and has primarily served the membership of B'nai B'rith. The project came into being out of the conviction of the Jewish Vocational Service that there was need for an educational program that would obviate some of the personality problems with which we were struggling in our educational and vocational-guidance program for adolescents and young adults.

Many of these arose from the need of the parent to project his own desires for ego satisfactions upon the child instead of accepting him as he is. The ambivalence we found in choosing a career was often the reflection of pressures of this kind or of dependent attitudes that had been fostered. These and other tensions, we felt, might be relieved if parents could be brought together in an informal atmosphere to discuss among themselves, with guidance, their own experiences and attitudes about their children's educational and vocational careers. Perhaps over a period of time, through the interaction of the people in the group, and the influence of the professional counselor who would direct the project,¹ there might develop a deeper understanding by parents of their children's needs and patterns of growth.

While the purpose of the program was to be child-centered, the method was to work through the parents, accepting them as they were and trying to build the strengths they had individually, and could get from each other collectively, toward

¹ The professional worker who conducted the project is a case-worker who has specialized in children's problems.

their greater effectiveness as parents, with special emphasis upon the rôle they played in shaping and planning their children's futures.

The technique of using free discussion was chosen as the way that would best reveal where the parents were in their understanding of their parental rôles, and keep the program most closely geared to their needs as parents as they saw them, or as the counselor could sense and point up the direction of interest. We believed, too, that through group discussion, learning could be translated more frequently from an intellectual concept to the kind of acceptance of ideas about parent-child relationship that could be carried over into action and changed feelings and attitudes.

Although we would exclude none, we were concerned primarily with the relatively normal child and parent, realizing the limits of our function, which was that of a vocational-guidance agency rather than of a case-work service. The emphasis was placed on working within the capacities of the people who came to us for a better utilization of their potentialities as parents. We would, therefore, build their feelings of adequacy rather than point up their shortcomings. In practice, we found that this atmosphere of acceptance promoted mutual acceptance within the group, although a high degree of this was already present, since we organized our groups from B'nai B'rith chapters, or other Jewish community organizations, where they had already had opportunities for working and playing together. This mutual acceptance helped them to overcome reticence quickly and discuss the problems of their relationship with their children freely and honestly.

Another result of this approach has been the relatively infrequent referring of members of our groups for individual therapy. Since the tenor of the discussions tended to allay rather than to heighten anxieties, there was less disposition for the members to look for special help, and even where the counselor felt that case-work service was indicated and made an effort to refer the parent for individual therapy, the members of the group tended to be satisfied with the group experience, except in the case of individuals who had discarded it rather quickly as not geared to their particular needs. Had we set out to stimulate the desire for individual treatment, we

would have had to focus upon the parents' inadequacies instead of making them feel, as we tried to do, that they could help themselves.

A pattern of organization for the group was set up that permitted the greatest possible responsibility for the mechanics of it to rest with the group itself and within the organization of B'nai B'rith, which sponsored the project. Only one group was originally organized on an experimental basis, meeting monthly in the homes of its members and drawing attendance of from four to nine people during the first five months of its functioning. As originally conceived, the leader would be one of its own members, the counselor being present, but in the background. The counselor's rôle was to train and brief the lay leader for leading the discussion; to stimulate interest in reading books and pamphlets designed for parents in the broad field of parent-child relationships; and to summarize the evening's discussion so as to heighten the group's awareness of what they had achieved during the session. She was also available to the chairman of the group, who had been appointed by the organization's president, for consultation on any problems that arose and to help secure interest in the project within the parent organization.

This original group served as a demonstration to B'nai B'rith of the value of the project, and in the fall of 1949 it was expanded to serve four additional B'nai B'rith chapters and three groups from other community organizations. In general these groups followed the pattern set by the first, with some exceptions. The new groups were led by the professional worker rather than by a lay member. This decision came from the worker's conviction that it was the leader who created the atmosphere and provided the avenues through which the group found mutual concern with the subject at hand and freedom to explore it with sincerity and sensitivity to one another's needs. Finding and developing leaders with this skill would take the counselor much time that might better be given to the establishment and integration of the groups.

The counselor has also continued to question whether a lay person can meet the demands of this rôle in the matter of knowledge of the deeper meanings of the contributions of the members—a knowledge that is needed to direct the discussion toward fuller understanding of the behavior described—and

in skill in helping members of the group to overcome reticence, when speaking out seems likely to reënforce acceptance of themselves and of their children, or to protect them from making disclosures that they might regret.

In the original group, in which the same lay leader has continued to serve, what has developed is the kind of rapport between her and the counselor that enables them to lead the group jointly, each aware of the limits of her function, which has been a gradually changing one as the group has matured in its use of this experience and in its interrelationships. During the second year of activity of one of the other groups, one of the lay members served as leader under the guidance of the counselor, but the group chose to return to the counselor's leadership after a year of trying out the other pattern.

One of the groups established in the fall of '49, from a chapter of B'nai B'rith that consisted of young married women with very young children, concerned itself from the start with subjects for discussion outside of the realm of educational and vocational guidance, the discussions relating to immediate problems of their relationship to their children. Since it was the counselor who helped the group determine what they would discuss, we had been able initially to keep the program within the limits we had originally set up for our concern. However, we wanted to serve the needs of the group, which we felt out step by step, at the close of each session choosing the subject for the next discussion and stimulating the group to indicate what their interests were. We were, therefore, already aware, at the end of the five sessions of the original experimental group, that discussions of parent-child relationships could not long be limited to one area in a setting in which, as discussion progressed beyond the superficial, parents began to see how all parts of the child's life were interrelated.

And as they began to see their children's school experiences in a new light, they were eager to try the same approach to a deeper understanding of children in the home and neighborhood setting. At the end of their first activity year, all the functioning groups were concerned with the larger purpose of providing an opportunity for parents to understand how personality develops and the rôle of the parent in the growth and maturation of the child. Within the past year, this has led

to a deeper awareness of the way in which the parent's personality plays a part in the child's development and to a concern about understanding adult behavior, so that they can see how they function with their children.

Except for the group already mentioned, for the parents of preschool children, there has been no homogeneity among the groups in the matter of the age of their children, and in general we have not found this a bar to mutuality of interest, although we know that some people have visited and failed to join the group because, at that particular time, children of the age of their own were not being discussed. Those who have stayed with the groups have said they have found that concern with children of various ages is valuable in giving them perspective. (Very recently, however, we have started the development of a new project, designed for parents of the B'nai B'rith Youth Organization, which is specifically oriented to the adolescent.)

One of the groups that has continued to meet regularly since its beginning in October, 1949, was organized to include both parents and has continued on that basis. We tried unsuccessfully to do this with two other groups and have experimented with an occasional meeting to which husbands are invited. One of the groups has had the steady participation of one of the husbands during the past year. Our experience with both-parent meetings has shown that, to be effective, the men must come because they want to and not because their wives think they should.

The discussion method, as a technique for this project, was actively promoted by the counselor, since this was a new experience for the participants, the merits of which had to be demonstrated. Our original decision to use it proved valid in the way in which the group acquired unity of purpose, and in the support that the parents had been able to gain from one another. Its validity was demonstrated, too, in the growth that took place among the participants as they began to show greater understanding of their children and acceptance of their behavior, either pointing up these evidences themselves, or having the counselor indicate where the evidence appeared. Along with the growing ease in the use of this method, however, and appreciation of it, there was recurring evidence of the wish for guidance from authority. The counselor met

this by occasionally bringing in a psychologist, a psychiatrist, or a social worker of outstanding repute, but in an effort to retain the distinctive nature of the project, she asked for no speeches from them, but rather that they serve as resources for the discussion. She also brought written materials, such as reports of the White House Conference of Children and Youth, the recording, *Meet Your Mind*, made by Dr. William Menninger, and a few films, such as *Preface to a Life*—all of which were used as a basis for discussion. The plays *Scattered Showers* and *Fresh Variable Winds*, put out by The National Committee for Mental Hygiene for parent groups, also were used as a basis for discussion, although originally prepared by two of the groups for presentation to the larger organization of B'nai B'rith as a device for publicizing and explaining the parent-education program. These experiences contributed some variety as well as external stimulation beyond that provided by the reading which the counselor was able to encourage.

By the end of the second year of the operation of our parent discussion groups, we felt the need for an evaluation study. The device that we used was an anonymous questionnaire. The anonymity was intended to provide an opportunity for freedom of expression, and a cover letter that accompanied it encouraged comment. We used it, not only as an evaluating method, but also to serve a number of other purposes. We involved the leadership in setting up the framework of the questionnaire, so as to deepen their awareness of the purposes of the project, and make them feel more creatively part of it. At least twenty people from the groups took part either in the process of formulating the questionnaires or in getting them disseminated and returned.

We also provided a wide range of opportunity for all the participants to contribute to the planning of future activity. The counselor received very helpful suggestions for the content of the questionnaire from Dr. Regina Westcott, Dr. Irene M. Josselyn, and from Mr. S. Z. Rosenbaum, research director for the local Community Welfare Council. It was designed to reveal the degree of interest in the project, the acceptability of the method, what the participants believed they were able to get from it, and what suggestions they had for enriching it or for gearing it more specifically to their own needs. It

was distributed to the over 200 people who had participated in the discussion groups and was returned by 95, 65 of whom indicated that they had been regular participants.

From those who had attended regularly came the almost consistent affirmation that the discussion method was preferred, although a significant number felt that a combination of discussion and lecture techniques was desirable. And even among those who had come seldom or only once, two-thirds liked the discussion method best. The value of this technique was again pointed up in what they felt they had been able to get from the project. Almost without exception, they said that they had gained by the discovery that their problems were alike and that accordingly they had learned much from one another.

More than half of the regular participants found relief in talking about matters that troubled them, were encouraged in their present ways of handling their children, or were able to discover what mistakes they were making. Many noted the positive value to them of finding fellowship with others out of this experience of sharing their concerns. Most of them said that they had gained an increased understanding of their families and were getting a better understanding of the way in which children grow. Two-thirds of them felt that the greater insight and ease they had achieved from the project had been carried over into a greater feeling of acceptance of their children and that they, therefore, became angry with them less frequently.

It is worthy of comment that one mother noted that she was able to get such subtle insight into her own needs that she could get angry with her children where before she had been inhibited. Two found from their greater awareness of both their children's and their own needs that they could spend less time with them. Many said that the project had led them to spend more time with their children. From two who had stayed with it, we learned that they had gained nothing of value to them, and three who had visited expressed this feeling, too. Unquestionably there were others who did not bother to return their questionnaires who did not find satisfaction in the project or who would not stay with it long enough to see its value.

Consistently from these questionnaires—particularly those

from parents who had stayed with the project and to a lesser degree from those who had visited it—there emerged the pattern that through this device they had been able to strengthen one another. Together, with guidance, they had then been able to go ahead to test out new ideas and assimilate some of them. All of this reinforced the counselor's conviction that these monthly discussions had brought discernible changes in the ways in which these parents saw their rôles and carried them out. Repeatedly, she saw a gradual change in many of them from a judgmental attitude toward behavior to an awareness that it is a clue to the needs of the personality, which the members were able to get from the attempt of the group to look beneath the surface for motivation. It was clear, too, that as they heard other parents complaining of behavior that had troubled them, they not only began to see it as a phase of growth, but could begin to let their children alone as their anxiety about it subsided. Perhaps the most positive effect was the growing evidence that these parents were enjoying their children more as they felt themselves more adequate.

During the past year, some changes were made in the program as a result of the questionnaires. While the discussion method has been accepted, it was also clear that the parents wanted more opportunities to digest what specialists in the field had to offer. It was also obvious that, although the project was concerned with the problems of children, the parents needed to understand themselves as adults better in order to see their relationships with their children more clearly.

A number of the groups, therefore, took Dr. Wm. Menninger's pamphlet, *Self-understanding, a First Step to Understanding Children*, and used it as a basis for discussion in its broad implications, some of them going into it so intensively that they have not finished with it after seven sessions of two hours each. The others used the digest of the *Fact Finding Report to the Mid-century White House Conference on Children and Youth*, dealing with the development of the healthy personality, as a framework for the discussion of how children's personalities grow, taking perhaps a page or two for material for a two-hour session.

Even with this change in the pattern of the discussion,

however, the philosophy is maintained that they seek primarily to share their experiences and explore their own feelings and reactions instead of simply absorbing scientific knowledge. The growth experienced by a few individual members who performed the rôles in the plays about parent-child relationships led the counselor to experiment a little with rôle-playing within the discussion groups in the past year, and greater utilization of this technique is planned.

Since the atmosphere of our parent-education project is highly informal and the mechanics of organization have been handled by the members, the statistical material available is somewhat sketchy. During the past activity year, 164 people participated in six groups that met monthly in a total of 46 meetings, 576 being the aggregate number attending. Some of these have been with their groups since they were originally organized in January and October of 1949; others have been with the project for one or two years; and new people have come in during the year just ended.

It seems clear that if the project can continue to grow to meet the needs of these participants, some of them will stay with it for some time to come. Others have already indicated that while they feel the value of the experience they had in the group, they had obtained what they could use from it and had, therefore, dropped out, and this process may be the most general one. However, the questionnaires indicated that 47 of the 65 who had been in regular attendance would seek another similar project if for some reason their own group were to disband.

This demonstration of the value to parents of a group experience, in which the dynamics of the group is the primary force, is in line with the findings of the Child Study Association of America. In their report of 1952, Aline B. Auerbach delineates their discussion program as "directed toward building on the healthy factors of parents' personalities and on their potential strengths in their family relations." Our experience has closely paralleled what she describes as happening in their groups, in which parents "gain a deeper, more lasting kind of learning through active participation and by evaluating the living realities they are facing against a background of wider, universal human experience."

Whether we will ever be able to measure its effects upon

the young people who will be coming to our agency for educational and vocational assistance, remains to be explored through the services that we are now giving or expect to give the children of these parents in our group and individual guidance programs. At present, we feel that our launching and continuing to carry this program has been rewarded by the benefits that the participants themselves have seen in it. The goal we set was to reduce the strains upon the children who are growing up in our Jewish community. In a small way, these results are being achieved.

Our project may also give impetus to other family-life education programs in our community in which within the past two years there has been a marked development in this field. Our own efforts have been limited to that part of family-life education which is concerned specifically with parent-child relationships. We do not attempt to explore husband-wife relations, the art and economics of maintaining a household, and the many other facets of family life with which the total field is concerned. From our own limited experience we see the greatest promise through this medium for wider dissemination of the results of scientific inquiry into the dynamics of behavior and the ways in which more satisfying and creative lives can emerge.

NEW PERSPECTIVES FOR TEACHERS— AN EVALUATION OF A MENTAL- HEALTH INSTITUTE *

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FOR the past three years, the Massachusetts Association of Mental Health has been experimenting with an idea that has significant implications for democratic living. In coöperation with educators, annual mental-health institutes have been conducted, the results of which, it is hoped, will ultimately be reflected in better mental-hygiene practice in the school. It is indeed encouraging that education is facing up to its task of sharing responsibility for developing well-adjusted personalities in all our children, so that they may successfully meet the pressing demands of modern American citizenship in this conflict-torn world. Viewed in this perspective, the deeper consequences of the mental-health institute that is about to be described and evaluated should become apparent.

On Saturday, September 27, 1952, the Third Annual One-day Institute in Mental Hygiene for Educators was held at the Beaver Country Day School, Brookline, Massachusetts. Its primary purpose was to create an atmosphere that would encourage the examination of subjective reactions to problems. "Know thyself" is a prime essential to an understanding of others. People meeting in one-day institutes and discussing their problems is not, of course, a novel idea. But this institute was unique in that educators worked together with psychiatrists, and the techniques of group dynamics were integrated with group therapy to facilitate the achievement of the institute's goals.

Such institutes help to do away with the detrimental stereo-

* The writer is indebted to Dr. Leo Berman, Dr. Henry Riecken, Miss Bettina King, Miss Roberta Kellogg, and Dr. Libbie B. Bower, as well as to the institute staff, for their collaboration in this evaluation.

types of psychiatrists that often prevail, according to which the psychiatrist is regarded as the last resort for the treatment of enervating and bewildering emotional conditions. The idea that there is a stigma attached to seeking psychiatric aid still hangs heavily over the teaching profession. In recent years, however, encouraging progress has been made in the advancement of psychiatry in education.

It is not too difficult to decipher the reasons for this changing attitude in education. Modern education views not only the acquisition of knowledge, but also the development of sound interpersonal relations, as its fundamental task. Of what value is it to master school subjects when personality defects prevent their utilization in normal, everyday affairs? Since the modern point of view regards interpersonal relations as essential to the teaching process, then the teaching process is one of producing change and the teacher is a primary change agent.

This seems to imply that there are definite therapeutic implications in the teaching process and it is reasonable for education to turn to the psychiatric profession for aid in these matters. The psychiatrist is, after all, a specialist in self-analysis, in the treatment of emotional problems, in assessing and encouraging good interpersonal relations, and in therapeutic change. For these reasons psychiatrists were selected as leaders for the discussion groups in this institute.

Integration of Group Dynamics and Group Therapy.—Originally, the Massachusetts Association for Mental Health was influenced in the development of these institutes by the Kurt Lewin school of group dynamics. Those who have taken the step know what a daring move it is to discard the traditional speaker-listener type of institute for one in which democratic group discussions are the central core. Undoubtedly, these early institutes developed skill in human relations by centering on the problem-solving process. But such gains were indirect, and it soon became apparent that an additional step was needed.

Group dynamics is situation- and problem-oriented. Its primary concern is with exchanging ideas on problems and assessing why the group was productive or unproductive in its approach to the solution of these problems. Group

therapy, on the other hand, is primarily concerned with the psychodynamics of the individual. The individual's underlying subjective reactions to problems is of central importance rather than the exchange of ideas. Group therapy feels that it is important to know why one reacts as one does to particular situations. Are there personality factors that hamper efficiency in given situations? The leaders of the institute felt that pursuing such questions would open the way to wider perspectives and facilitate the handling of these problems.

Obviously, such institutes cannot go too deeply into examining the subjective reactions of the individual. Participants are not going to talk about themselves in a very personal way. Touching lightly, however, upon subjective reactions in a one-day institute can give a clearer perception of the nature of the problem and a greater ability to determine whether it is an objective or a subjective problem. There are other values which the ensuing examination of the institute data will reveal.

One may ask, "How does one keep self-examination within limits?" Participants are not expected to talk about their intimate problems in a group of strangers. On the other hand, it is often very difficult to get people to undergo even a limited process of self-revelation. It is at this point that group dynamics and group therapy join hands. A skilled leader, with an understanding of group-process techniques, can steer the group along the middle lane, striking a balance between bringing up material too painful for the group and not bringing up sufficient material, thereby negating the basic purpose of the institute. Group discussions are the heart of the institute and the medium through which the subjective components are scrutinized. This approach is valuable because introspective insight facilitates our understanding of the emotional behavior of children and colleagues as well as of our own behavior.

In the last analysis, one of the long-range goals of the institute is to contribute something toward making the participant a better teacher. The teaching process is designed to promote the growth of children. But also implicit in the teaching process is the growth of the teacher. These objectives must proceed concomitantly.

In a sense the discussion group is the counterpart of the classroom. Here the teacher, via permissive interplay, gets a personal idea of the feeling overtones of learning experiences. Through the operation of group process, the teacher achieves a twofold gain—a deeper insight into the dynamics of the classroom and to some extent a greater understanding of personality dynamics. One can readily see that to-day's teacher cannot depend upon traditional training and skills which may have been successfully applied in the past because of a narrowly confined conception of learning. The new conception of learning, in which behavior is altered by experience, requires a changed orientation and the application of new skills to bring about the desired result of better personality integration and social adjustment. The mental-health institute, with its emphasis on a combined group dynamic-group therapy approach, is one important means of developing these new perspectives.

Developmental History of the Institute Idea.—In 1950, the Massachusetts Association for Mental Health came up with the germ of an idea which impressed them as having value for promoting mental-hygiene education in the schools. After some floundering, the idea unfolded of a mental-health institute that would incorporate the principles of group dynamics and group therapy. Characteristically, the ramifications of this notion were not well visualized.

Thus, out of interest in the positive aspects of mental health, an institute was planned. A planning committee, composed of educators and representatives from the field of psychiatry and group dynamics, was organized. It was felt that psychiatric aid would be most welcome in making the committee aware of the complexity of psychodynamic factors in the individual and that group-dynamics techniques would provide effective methods in planning mental-health programs. Over and above these two factors was the recognition of the need for training educators in mental-hygiene principles and concepts conducive to furthering the learning process and the emotional well-being both of the child and of the teacher.

The first institute in mental health was held at Harvard University on Friday, October 13, 1950. Dr. Roma Gans, of Teachers College, Columbia University, was secured as the

guest speaker. Her task was to provide the orientation, the frame of reference, for the problem areas selected by the participants. Groups of fifteen were formed and the participants joined a discussion group of their own choice. The following problem areas were delineated by the institute planning staff: The Implications of Compulsory Attendance; Why Children Fail; Social Control in the Classroom (Discipline); The Relationship of the P.T.A. to the School Program; Special Problems of the Atypical Child (the Bright and the Dull); Dynamic Relationships Among Children; The Nature of Authority; The Personality of the Superior Teacher; The Place of the Psychiatric Social Worker in the School; and Teacher-Principal Relationships as They Affect the Child.

On the whole the response to the new kind of institute was good. One direct constructive result was the recognition by many participants of the need for a more intensive group experience spread over a period of time. This led to the development of seminars for professional people based on group-psychotherapeutic techniques. However, as might have been expected from an initial effort, mistakes were made and dissatisfactions were voiced about the problem areas as outlined. For the second institute, the areas for discussion were generalized under four headings: (1) Emotional Reactions to Children; (2) Emotional Reactions to Adolescents; (3) Emotional Reactions to Colleagues; and (4) Administrative Interpersonal Relations. This arrangement worked out so well that it was continued into the third institute, but with some modification.

In the first institute, the educators had difficulty in getting accustomed to psychiatrists as group leaders. No doubt the false picture that many educators carry in their mind of psychiatrists—namely, that their sole function is to treat the mentally ill—exerted a deleterious influence. In fact, there was a great deal of resistance to psychiatrists as group leaders, and in some instances open hostility was expressed. On the other hand, the psychiatrists experienced some anxiety and insecurity because of their lack of familiarity with the educational content under discussion. There was considerable feeling that the leaders were not clear about their rôle.

The second institute made provision for educators to serve

as consultants in the various groups. Their function was to assist the psychiatrists by clarifying problems of an academic nature, so that the group could proceed to interact on a feeling level. "Spark plugs" were tried in the second institute, with the idea that they would facilitate group interaction. They were discarded, however, in the third institute because they did not prove useful.

One of the important issues raised by the first institute concerned the question of the homogeneity of groups. In this connection, two aspects were considered: (1) should the advanced be segregated from the non-advanced participants, and (2) should administrators be segregated from teachers? Although there was some fear that teacher spontaneity might be stifled in a mixed group and that administrators would monopolize the discussion, the second institute favored intermingling individuals of all status levels.

Similarly, there was no attempt to segregate the advanced from the non-advanced—that is, those who came to the institute for the first time. It was felt that the advanced participants could well act as catalysts in the group. Heterogeneous structuring was advocated. The belief was that the clear titles in the aforementioned problem areas would bring about a homogeneity of interest and that this was far more important than a homogeneity of rank.

In the third institute this position was reversed. It was decided that the sessions on "Administrative Interpersonal Relations" would be open only to the administrators. In addition, there would be an advanced discussion group open only to those who had attended previous institutes or group-therapy seminars. The reasons for this reversal were two-fold. Statistical evidence indicated that at the institute there was a dearth of administrators, especially high-school principals. Consequently, a special effort was made to interest that group by placing them in an exclusive unit. Also, an advanced group was set up to enable those with previous institute or seminar experience to proceed at their own speed. In this way it was felt that they would not be fettered by the usual flounderings characteristic of the inexperienced. As we shall see, this assumption was not borne out in experience.

Planning the Institute.—A new kind of institute demands a

different conception in planning. If the objective of the institute is to develop maximum involvement and participation, it is logical to lay the basis of a new cognitive framework in the planning stage by drawing in the future participants themselves, instead of relying simply on "experts." Naturally, it is not possible for all to participate in this phase, but a representative cross-section can be secured. Accordingly, a planning committee was set up, composed of individuals from the sponsoring agency, personnel from the school field, psychiatrists, and others anxious to make a contribution.

Planning based on democratic participation should begin early. It takes time for participants to become sufficiently ego-involved to thrash out vital details and determine what ingredients go into the making of a successful institute. Even though we had the benefit of lessons learned from two previous occasions, we still began to plan the program eight months in advance.

Selected individuals were given a training and orientation session in the new techniques of content recording and process observing. Each discussion group was assigned both a content recorder and a process observer. As a result, a wealth of intriguing notes and observations were recorded for later study. The function of the content observer was to record in developmental fashion the content of group thinking. Pros and cons on major issues or problems, solutions, decisions, and recommendations constituted the material for recording. The process observer, on the other hand, looked at the way the group functioned and was concerned with recording the interaction of the participants, so that we might have some idea as to why the group behaved as it did.

The planning committee established a program which combined the lecture type of presentation with the self-motivating group discussions. Such a prospectus is not a refutation of the goals we cherish. Participating in a program in which the workshop method is employed constitutes a new and radical departure to many individuals. Thrusting them headlong into such a situation may prove to be threatening and traumatic. Deep-rooted dependency needs cannot be ignored. Conversely, dormant needs for self-assertion and creative

expression must be stimulated if our goals are to be attained. The integration of these two factors underlay the design for functioning as projected by the planning committee.

The Third Institute Program.—The program opened with a penetrating talk by Dr. Leo Berman, a psychiatrist who had been involved in the work both of the institutes and of the seminars from the beginning. His task was to provide the rationale for the institute and to give some suggestions as to how the participants could perform in the discussion groups. In essence he set the tone for the group discussions that followed and paved the way for the development of a permissive atmosphere in which feelings of uncertainty could be alleviated and problems freely ventilated.

Discussion periods, one in the morning and one in the afternoon, were one hour and a half in length. Fourteen groups were organized and the number in each was purposely limited to from 12 to 15, to assure face-to-face contact and an opportunity to get acquainted early. In this way free exchange of opinion could be facilitated. Groups also had the chance to jell more quickly than usual. Furthermore, the psychiatrists, serving as group leaders, conducted their sessions in the fashion outlined by Dr. Berman. With some help from the leaders, a variety of problems were discussed and covert emotional factors relevant to these problems were uncovered.

Upon completion of the group discussions, Mrs. Helen Dennison gave an informative and entertaining demonstration on "How to Use Hand Puppets in Group Discussion." There were also informal periods, such as at the lunch and dinner table and during the sherry hour, during which problems were heatedly and incisively analyzed. These informal sessions offer concrete evidence that constructive learning is not confined to the formal aspects of the program. The day was colorfully and successfully concluded by Dr. Jack Ewalt, Massachusetts Commissioner of Mental Health, when he synthesized the proceeding with a speech appropriately titled "Your Emotions from 9:00 to 3:00."

Capacity attendance, with approximately 178 participants, seems to indicate that this institute has struck a responsive chord in the Massachusetts schools. Geographically, 43 Mas-

sachusetts communities were represented, mostly from the eastern sector. In addition, there were four individuals from the state of Maine and one from Vermont.

What Do Educators Talk About?—Notwithstanding the fact that this was a one-day institute, the substance of the different discussion groups was penetrating and highly illuminating. It is obvious that these educators were deeply concerned with the question of mental health and its implications for the school. There seemed to be a tacit recognition that mental hygiene is an integral aspect of curriculum development with roots extending beyond the school into the community.

What did the participants talk about? What basic problems did they seem anxious about? Of general interest is the fact that, even though specific subject-matter areas were established, the discussion in each group extended beyond the topical categories. A common thread centering around the importance of interpersonal relations ran through all the groups. Discussion was carried on through a frame of reference which pointed up the relationship between the common thread and the development of self-insight.

From the give-and-take of the day's inquiry five major problems areas emerged: (1) Interpersonal Relations; (2) The Question of Authority; (3) Parent-Teacher Relations; (4) Problem Behavior in Children; and (5) Problem Behavior in the Teacher.

Interpersonal Relations.—Implicit in all the issues stemming from the interchange of opinion was the central importance of interpersonal relations in the teaching and learning process. Furthermore, interpersonal relations are all-encompassing and are not restricted merely to the classroom situation. The school program must be viewed in its totality, the interplay of human relations involving not only interpersonal relations between teacher and child, but also interpersonal relations within the teaching staff, between teacher and administrator, between teacher and parent, between teacher and community citizens, and between the children themselves.

The Question of Authority.—The question of authority was unequivocally the central issue examined in the groups devoted to administrative interpersonal relations and emo-

tional reactions to colleagues. Other groups, however, were not unmindful of its weighty influence upon the school situation. From the emotionally charged content it was readily apparent that authority relationships constitute the fulcrum upon which levers can be applied for transmitting forces that lead to good or bad mental-hygiene practice in the school.

The need for a status hierarchy based upon professional responsibility and authority was not questioned. Nevertheless, the autocratic administrator is definitely the bane of the teacher's existence. Democratic administrative interpersonal relations were affirmed as the best means of fostering experiences that enrich human relationships.

Teachers felt that, wherever feasible, teachers should plan with the administrator. Not all decisions, of course, need be based upon coöperative action. Teachers understand that certain decisions lie solely within the realm of the supervisor, just as certain decisions reside within the orbit of the teacher. But sharing in decisions encourages closer working relationships essential to effective administration. Teachers also feel the need to be regarded and respected as individuals in their own right. Creativity in teaching depends greatly upon the administrator's respect for individual differences.

How does the teacher react to the authoritarian, the administrator who limits freedom of action and sets up an inflexible action structure? Several reactions were given as examples, but basically the chief manifestation is either hostility or passivity. Frustration is rampant when there is a reality conflict with ideals and expectations.

Authoritarian administration adversely affects interpersonal relations among colleagues. Often there is a resentment against authority for unfair distribution of the teaching load. Professional jealousy becomes a festering sore, insidiously operating to the detriment of the school program. In this hostile atmosphere, no teacher can work closely with the administrator for fear of being thought of by his colleagues as an "apple-polisher."

The participants appeared to have only a dim awareness of the dynamic forces underlying the autocrat's behavior. There was, however, a recognition that understanding the psychological factors would give them a more complete under-

standing of why the administrator behaves as he does. Some felt that the administrator was beset with anxiety because of the legal responsibility of authority. Others wondered if he wasn't just anxious because of the difficulty of finding the proper degree of distance between himself and those he leads, in order that a proper balance may be attained between being too hard-boiled and too easy-going. Again, others pointed out that the administrator is, after all, confronted with the basic dilemma of ruling and yet being responsible to a higher authority; that often it is with reluctance that he issues orders that emanate from above. Still others were exploring the idea that perhaps the autocratic administrator has some doubts about his position of authority and his adequacy in it. He may feel it necessary to stay in the driver's seat because of his inability to delegate authority, or because he feels a threat to his status by an energetic teacher. Finally, some hinted at the genetic factors implicit in the autocrat's personality development. Our attitudes toward those over and under us may be influenced by our early relationships, especially those with our parents.

One factor clearly emerged from this welter of discussion of the question of authority: The pattern or tone for the human relationships in the school is distinctly set up by the administrator, and this pattern frequently extends to the community. This is especially evident when frustrated teachers displace their aggression against parents, making fruitful parent-teacher relations very difficult or well-nigh impossible.

Parent-Teacher Relations.—No one will deny that parent-teacher relations are crucial. The intensity with which the groups discussed issues in this area attested to its vital significance. One of the major problems in parent-teacher relations is that teachers and parents frequently differ in their perception of situations. The result is an inability to communicate on matters of common concern, with consequent detriment to the child. This, of course, is contrary to the desires both of parent and of teacher interested in the pupil's welfare.

One reason cited for perceptual differences between parent and teacher was differences in background. The difference may be cultural or it may be educational. Diversity in cultural background must be clearly understood by the teacher

or she may be thwarted in her attempt to deal satisfactorily with the children under her guidance. Very often problems are created because the school has one set of expectancies for the child and the home another.

Differences in educational background also are often responsible for impeding parent-teacher relations. This may be because the teacher feels superior and cannot reach common ground with the parent. Conversely, the parent's meager educational training may stimulate feelings of inferiority in the presence of the teacher. Again, parents may have superior educational training. The parents' aspirations for their children may be set at a level higher than their children are capable of reaching. Pressures may be exerted upon teachers to produce results that are unattainable.

Expecting too much from the teacher may take another peculiar twist. Very often parents who cannot handle their children's problems will expect that teachers can "fix everything." In some instances, of course, the teacher is better able to handle a problem, serving as a parent surrogate and providing the child with the love he needs. Thus, behavior in school is often better than behavior at home. This, in turn, may be a source of friction between parent and teacher. On the conscious or unconscious level, the child is often an object of rivalry between them. Suspicions and hostilities of parents may be reflected in the attitude of the child toward the teacher. When the teacher attempts to straighten out a situation, often the net result is increased tension and difficulty because the parent may have an overprotective attitude, coupled with the attitude that the parent is always right.

Nevertheless, no one disputed the contention that greater coöperation between parents and teachers is needed. Teachers talked about the importance of changing parental attitudes, but obviously the reverse is true also. Teachers will have to change their attitudes toward parents. Herein lies a clue to poor parent-teacher relations—an inability or an unwillingness to see the other side of the story. The suggestion was made that much more could be done through parent-teacher associations than is usually the case. These organizations could become the real instrument for improving teacher-parent relationships.

Problem Behavior in Children.—The problems of children

were thoroughly discussed in the groups concerned with the emotional reactions of children and adolescents. One can infer from a comparison of the content of these respective groups that teachers deal essentially with similar behavior problems in children and in adolescents. There was some appreciation, however, that maturational factors may be responsible for certain problems that are characteristic of one age group rather than the other. Many facets of problem behavior in children were explored, but the fact that stood out in the discussion was that the aggressive or hostile child was considered by the teachers to be their major problem.

It is interesting that, even though mental hygienists and others have stressed continuously for the past twenty-five to fifty years that the withdrawn and submissive child is potentially a greater problem than the aggressive child, the teacher has generally been slow to grasp the significance of this point. The institute offered emphatic evidence that when the teachers were discussing the aggressive child, strong feelings were aroused. Undoubtedly this mirrors the teacher's behavior pattern when she is dealing with the aggressive child in the classroom. A child that is aggressive is a disturbing factor, and the teacher as a person finds it difficult to take hostility. Thus, instead of channeling the aggression into constructive channels, she feels compelled to eradicate it. Obviously this is seldom even apparently successful and usually only reenforces the aggressive behavior and increases the expressions of hostility.

All participants seemed to be acutely aware that the teacher's attitude toward the child is all-important. Attitudes are infectious and children are quick to catch the spirit in which you relate to them. It was brought out, for example, that placing the slow child in such classes as the home-economics or manual-arts classes without careful evaluation constitutes an evasion of responsibility. Very often the teacher looks upon these classes with scorn and the child senses the stigma that is implied.

There was some recognition also that teachers do react strongly to children's problems. Tenacious feelings of frustration and inadequacy persist when teachers are unable to deal successfully with them. Then again, teachers fear the

pressure of community opinion when they fail to arrive at a successful solution. Some teachers discerned a similarity between problem behavior in children and the problems that were typical of their own childhood.

Teachers freely admitted that not all children are treated alike in the classroom, and this admission did not occasion any strong feelings of guilt. Differences in treatment were considered reasonable so long as fair standards of treatment were upheld. Some teachers felt that some children were "repulsive" and could not be accepted by them. Rationalizations were prolifically offered as justification for their right to dislike some pupils, but what was overlooked was the impact of such attitudes upon the teaching and learning process. In some instances a note of futility could be detected in their consideration of ways to handle these problems. One teacher exclaimed, for example, "Disturbed children come from disturbed homes. What can we do about it?"

In contrast, another point of view expressed was that some of our concerns and involvements in the problems of children may be subjective. What one teacher conceives as a problem may not be so regarded by another teacher. Clearly teachers need to understand a great deal more about what constitutes problem behavior in their pupils.

Although no definitive answers were given, constructive consideration of basic problems in this area proved fruitful and stimulating. Especially encouraging was the realization that teachers cannot be impersonal in the handling of children. As soon as possible they must establish rapport with their pupils and help create a classroom climate in which the emotional needs of children can be satisfactorily met. In other words, teachers are key persons in the handling of problems in children. Therefore, they are obligated to make a realistic appraisal of the situation.

Some of the suggestions mentioned for improving a teacher's effectiveness in dealing with problem situations are worth noting. The potency of the peer group was slightly touched upon, but the teachers were rather vague as to how they could manipulate peer groups for constructive purposes. Generally, in-service training courses in mental hygiene were recommended as the best way to increase the teacher's effec-

tiveness. But better pay, more teachers, and smaller classes were also mentioned as necessary. Teachers should work closely with the guidance service and should know when to refer a child to a specialist. Finally, school authorities and the teacher should be concerned with the teacher's own mental health, since sound interpersonal relations between teacher and pupil are the best antidote to problem behavior in children.

Problem Behavior in Teachers.—Concern for the mental health of teachers is relatively recent. Curiously, while a great deal of attention has been devoted to the welfare of the pupil, the welfare of the teacher has been ignored. To-day we recognize that the emotional well-being of the teacher is vital to any school program. A large percentage of failure in teaching can be attributed to personality maladjustments.

In the past when teachers got together to expatiate upon their working problems, the subject of the teacher's own mental health was "*verboten*"—never included. Times have changed, and this institute is certainly a reflection of the candor with which teachers to-day face emotional problems. Teachers commented freely and frankly upon the subjective elements in the teaching situation. They seemed to understand that they could not afford to taboo this subject any longer if the school was to achieve progress in mental health. Although they did not probe too deeply, the following material emerged from the various discussion groups:

There was explicit awareness that the teacher's personality may have a disturbing effect upon the children and that there are teachers whose personalities are not wholesome influences on those they guide. But, generally, they were quick to point out that the teacher's job, by its very nature, may set up tension.

Fear and anxiety in teachers arise from a number of sources. Attitudes of the community toward the rôle of the teacher may be unrealistic. Uncomfortable relationships with authority seem to be considered the greatest source of fear and anxiety. The importance of democratic administration for the emotional well-being of the teacher has already been mentioned.

Frustration in teaching is a common experience. The

teachers felt that some sort of emotional release was necessary to counteract the effects of frustration. Unfortunately, unwholesome expressions of aggression were often the end result of frustrating experiences. There was a recognition that teachers often displaced their aggression upon their students when they were emotionally upset toward the principal or other teachers. The situation often worked in reverse also, the emotional strain of working with children affecting the teacher's relationship with other teachers. There are times, of course, when the teacher is annoyed by actions of her students and counters with a direct expression of aggression against them. Sometimes she feels better after this happens, but more than likely she is plagued by guilt feelings when such an incident occurs.

It can be seen from the trend of the discussion that the groups were quite productive in offering suggestions as to the causes that muddle the teacher's mental health. But, curiously, little discussion was devoted to remedial measures. Apparently the stigma of psychiatric treatment still presents a bugaboo for most teachers. One constructive suggestion was made, however, relative to dealing with children, which might have as a secondary effect a salubrious effect on the teacher's mental health. This idea was expressed as follows: If, in addition to the teaching of subject matter, the teacher is expected to play many new rôles in modern education, such as satisfying the emotional needs of children, spotting personal maladjustments, serving as a parent surrogate, and so on, then she must be fortified with adequate training to enable her to understand and help these children. There is no doubt that we must expand our work in mental health in the teacher-training institution, in the schools of education, and in in-service training courses.

That the teachers were keenly analytical is reflected in the universal acknowledgement that their own feelings and attitudes in all these problems discussed at the institute may be significant factors.

What Happened in the Groups—Process Analysis.—A perusal of the observer's reports dramatically reveals the numerous processes of interaction that occurred in the fourteen groups. In the various groups such facets of group living

as the following were evident: (a) stresses and strains were common; (b) satisfactions or dissatisfactions were expressed; (c) resistance, aggression, and hostility were manifested; (d) disrupting or cohesive forces were present; (e) struggles for power erupted; (f) dominance was successfully controlled; (g) isolates, subgroups, and special-interest groups appeared; (h) rivalry for leadership threatened unity; (i) the spontaneous enthusiasm that comes with the "Eureka" experience of gaining insight developed; (j) status hierarchies with functional rôles developed; and (k) efforts to reach stated goals and efforts to block them were made.

On the whole, the group atmosphere was congenial and conducive to a productive interchange of opinion. With few exceptions, the process was characterized by a tempo that was slow or moderate in the early part of the morning, building up to a peak of enthusiasm and productivity just before lunch. Afternoon sessions began at a rather moderate tempo with a relatively rapid propulsion into a work level equaling or exceeding in intensity that reached just before the close of the morning sessions. The few groups that did not attain this rhythm failed to do so because drop-outs had a decided effect upon the productivity of the group. In these groups the tempo of the morning session was similar to that of the other groups, but the afternoon sessions lagged badly and the high peak reached in the morning was never recaptured.

The Drop-Out Situation.—It is interesting to note that in these groups the drop-outs were deviants from group opinion and, although there was an effort to bring them into the fold, these efforts apparently failed. The groups were prepared to begin discussion in the afternoon session at the point where they had left off in the morning, but the change in the composition of the group compelled alterations in the agenda.

Perhaps the drop-out situation was the most perplexing problem uncovered by the process analysis. Drop-outs in the afternoon session were encountered in every group and the ensuing change in group composition had a definite impact. Interestingly enough, some of the psychiatrists were apparently perturbed by the drop-out situation and seemed to regard the absence of group members as a reflection upon their leadership ability. Their suspicions were groundless,

however, for the leadership factor as a causal agent was negligible.

When you look at the reasons for people's leaving a group, both the individual and the group should be considered. In the first place, at these institutes there seems always to be a normal process of membership attrition. Individuals will leave the group for reasons irrelevant to the kind of leadership or the program as set up by the institute. Some participants did not intend to remain for the afternoon sessions because of other commitments. A few of these individuals notified the leaders that they would not be coming back in the afternoon. Others did not leave word that they were not returning and this caused some concern among the leaders.

A different sort of reason for drop-outs was the group's inability to meet the expectations and needs of its members. In the group in which a controversy raged between traditional and modern education, the supporters of traditionalism had taken such a verbal battering that they failed to reappear for the afternoon session. Friendship cliques, in which the members mutually supported each other, did not return when their point of view represented deviant opinion. In one group there were six drop-outs apparently due to the disappointment of the individuals in question at not getting package answers to their problems.

Some members may leave because they question whether the group needs them or wants them. Isolates, for example, tended to drop out from the groups, generally expressing feelings of anger, of helplessness, and, in rare instances, of martyrdom before their exodus. One observer chronicled the failure of three resistant members to appear in the afternoon by speculating upon the fact that increasingly uncomfortable questions asked by other group members made it more profitable for them to be absent. An interesting situation cropped up in one group. One member was goaded by others to tell more of her personal life than she felt was warranted. When she did not show up at the beginning of the afternoon session, the rest of the group discussed this situation with great insight and with feelings of guilt. When she finally put in a late appearance, the group was much relieved.

Effects of Changes in Group Composition.—Changes in

group composition due to drop-outs were responsible for two contrary kinds of reaction—either a lessening or a heightening of productive group interaction. Here are some examples: When the supporters of traditionalism failed to reappear in the group in which they had engaged in controversy with the progressive educators, the discussion became rather dull and apathetic because the group seemed to be much more homogeneous in opinion, and incidentally were of the same sex. The fact that the drop-outs, four in number, were males is interesting in itself. Several observers remarked that where drop-outs were members of the male sex, discussion in the afternoon session noticeably lagged. In another group, when three resistant members did not come back, the group was at last able to produce observations of insightful value. Again, when the problem-prescription seekers were derelict in attendance, the members in this group began to show a good deal of warmth and friendliness toward one another.

The introduction of new members had an interesting effect upon the groups. Conceivably, there could have been the same twofold reactions as characterized the drop-out situations. According to the records, however, new members seemed to have a catalytic effect upon the groups. In one group, for example, the introduction of a new member helped to crystallize different philosophies between private- and public-school teachers. Another group was described as showing active participation with good interest, but marked with anxiety and fearfulness about becoming much involved. This pattern was changed by the entrance of a new member who brought up an excellent example of difficulties in her relationship with her superintendent. Discussion immediately focused around this harassing problem, and some degree of involvement and self-examination was gained vicariously.

Groups Need the Opportunity to Grow and Function.—At this point it might be prudent to reexamine the rationale set up by the institute planners for placement in the groups. It may be remembered that groupings were based, in addition to the participant's interest, on whether or not he was a beginner in this type of institute. An advanced person was defined as one who had had either previous institute or previous seminar experience sponsored by the Massachusetts

Association of Mental Health. It was felt that making this division would enable the advanced participants already familiar with the goals of the institute to plunge immediately into an examination of their own involvements in problem-centered situations. However, it was found that in every group, regardless of whether it was a beginners' or an advanced group, there was initial floundering characterized by obvious sparring tactics before members were able to get down to the business of the day.

How can we account for this paradox that both beginners and advanced groups seemed to undergo identical patterns of movement? A knowledge of group dynamics tells us that every group, short-lived, long-lived, casual, informal, or formal, goes through a maturational process in which it is born, grows, and dies. Thus, although advanced participants were placed in advanced groups, they were in an entirely new group, different from the one they were in the year before. Here, as in the beginners' group, there are many covert factors in the opening period of a group. Participants size up the situation, to determine what their rôle will be in the group, wonder who will be involved in the struggle for power and on what side, what the leader has to offer, and finally whether their needs and expectations will be satisfied in this group. Tension and uncertainty are naturally present until the participants feel that they can speak with security. This process of getting acquainted is an inevitable feature that all new groups must pass through.

One could question, of course, whether the so-called advanced groups were in reality homogeneous advanced groups. Apparently, attendance at previous institutes could not be equated with participation in the group-therapy seminars, which lasted for a much longer time.

Formation of Subgroups.—Subgroupings are a natural occurrence in any group. No matter how homogeneous a group appears to be, homogeneity is a relative affair. Even in those groups in which members seem to feel closely related, subtle differences exist which ultimately lead to subgroupings. This phenomenon was observed in all the groups at the institute. Furthermore, subgroup members more often than not perceived themselves as apart from the other group members,

and tended to interact more freely within the closed shop. Alliances that formed were either temporary, as the group moved from question to question or developed a question at length, or they were of a more permanent nature, individuals standing up together to be counted. Although not necessarily true in all cases, there seemed to be a significant correlation between the nature of the subgroupings and the drop-out situation.

A cursory inspection disclosed a variegated pattern of subgroupings, some on a horizontal basis and some on a vertical basis, in which status hierarchies were the differentiating elements. There was a tendency for groups to divide over familiar issues. In this fashion proponents of traditional education lined up against those of modern education. Similarly, there were instances in which the older teachers seemed to ally themselves against the young teachers. Almost snobbishly, the latter group seemed more confident and conversant with modern educational theory.

In the advanced groups, members with former seminar experience tended to band together. These were the ones who did not wish to drown in a sea of academic ritualism, but preferred to probe in a more introspective fashion. On the other hand, there were times when those who wanted to skirt around emotional problems were inclined to form their own subgroup. Parallel groupings frequently occurred among those who were rigidly resistant to group-dynamics methods and, conversely, subgroups and friendship cliques were not uncommon. For example, superintendents tended to gravitate toward one another and guidance directors did likewise. Cliques were observed among teachers from the same school or community. In some instances they reinforced one another and were unwilling to unbend, regardless of the issues discussed.

Two other situations ought to be presented, even though they do not strictly represent true subgroupings. Nevertheless, they have significant dynamic features in common. In some groups there were individuals who were in effect isolates. For a large part of the time they were out of contact with the group or they were virtually ignored by other members. In one group, for instance, an observer reported that its com-

position of all administrators and one teacher seemed to make both sides uneasy, and that the teacher's comments were comparatively ignored. The other situation presented itself at times when the group rejected some idea by the leader. At this point it was the leader against the group. But these moments were infrequent, as the dependency needs of the groups for the leaders were too great.

Subgroupings are powerful forces for stability or instability in groups. When they are able to adjust among themselves, interaction is harmonious and stability assured. But when mutual adjustment is not being effected, there is a trend toward the regulation or elimination of dissenting individuals or subgroups, with a resultant change in the composition of the group.

Leadership in the Institute.—It is readily apparent from the content material and the problems emerging from the interaction process that skilled leadership is vital. The prime task of leadership was to achieve the goals of the institute. These goals, as previously stated, were to establish security for the individual in a social environment in which he would feel free to regard any problem situation that occurs at work in terms of why he reacted to the problem the way he did. Obviously this requires certain skills and attitudes in the leader. Primarily he must possess skill in interpersonal relationships and an ability to handle situations as they emerge in group process. Furthermore, the attitude of the leader cannot be too distant from the group in which he is to function or else communication blocks will pose obstacles too difficult to hurdle.

Achieving the goals of the institute, of course, was not a simple task. Very often the expectations of the leader do not correspond with the expectations of the members in the group. Actually, some leaders did express a concern that they had set their sights too high and in fact were frustrated because their expectations were not realized. On the other hand, satisfying the individual needs and tactfully handling all the problem situations that arise in the groups requires the deftness of a tight-rope walker and the endowment of a Houdini.

Groups differed in their rate of maturation and such differentials posed road blocks that in some cases were not

easily removed. Some groups apparently operated more or less under their own steam, with little or no direction from the leader. Other groups, operating at a less mature level, probably could have benefited, as one leader indicated, from more steering, more coördination, and more interpretation of issues than they received. The basic difficulties in achieving institute goals were clearly implied when this leader succinctly stated: "I am consequently leaning toward the idea that the variation in group composition, activity, and expectations from group to group is such that standardization of the leader techniques employed is difficult or even unwise. With similar groups in the future, I plan to evaluate the group more quickly and permit greater flexibility in my leadership toward compromising with the needs of the group. I have the idea that molding of the leader in the direction of the image desired by the group may result in a more successful and gratifying meeting than my prior less flexible attempts to mold the group toward the free-discussion ideals aimed at in the institute. This compromise for those who need it may increase the interest and eagerness for future participation with greater freedom."

A variety of leadership techniques were utilized by the psychiatrists in conducting their groups. Standardization, however, was not a factor, as the leaders employed techniques consonant with their own experience and the immediate group situation. The one exception to the practice of diversity was in regard to opening the meetings. All leaders were requested to have the participants introduce themselves, and tell a little bit about their background and experience. It was felt that this method serves as a good ice-breaker, allays somewhat tensions and anxieties, and creates a warmer climate in which the day's activity can take place.

The type of leadership ranged from a purely non-directive rôle to one that was clearly directive. Some leaders seemed to identify with the group, others were passive, and in one group the members felt that the leader considered himself outside or apart from the group. It should be pointed out that the leader's behavior patterns were somewhat analogous to that displayed by the members. Uncertainty and indecision seemed to characterize their actions in the beginning, but as

they moved toward the afternoon sessions self-confidence and assurance was the dominant note.

Response to Leadership Performance.—Response to leadership performance was generally well received. Although most participants thought that the leadership was excellent, there were a sprinkling of disgruntled opinions. Lingering resistance toward psychiatrists was also manifest in one group. During the period when the participants in one group were filling out the post-meeting evaluation sheets, the leader stepped out of the room for a moment, and his exit gave one member an opportunity to ask the group if they would have talked more freely without a psychiatrist as leader. When several persons nodded, this same person suggested that it might be wiser, in future institutes, to use psychiatrists as consultants, with educators playing the leadership rôle. Such a change, of course, would alter the complexion of the institute and would be essentially a negation of present aims and purposes.

Comments from the reports of observers and reactions garnered from the post-meeting evaluation sheets reflect the spread of response to leadership. Two contrasting reports from observers are as follows:

“The group seemed quite satisfied with the rôle the leader played. He put them at ease in the beginning and stepped in when things got too disturbing.”

“I cannot help feeling that the leader was too passive in this group, except at the point where he overinterpreted in the early afternoon sessions. I feel he overlooked a number of opportunities to focus the discussion on feelings or on relationships and to penetrate beyond platitudes, such as, ‘It is a matter of personality,’ or, ‘It depends upon the individual.’ ”

The post-meeting evaluation sheets of participants also displayed a wide range of reactions, from complete satisfaction to real dissatisfaction.

The powers of a clairvoyant are not necessary to discern that meeting the diverse needs and expectation of group membership was a formidable task for the leader. His efforts were not always crowned with success, nor was it necessarily wise to satisfy all needs, especially those of a dependent and immature nature. One of the major difficulties that leaders had to contend with was the incessant demand for package

answers. Some members bluntly asked for prescriptions to take home, which would, like a magic wand, cause all annoying problems to disappear in thin air. When direct answers were not forthcoming, some of these individuals were violent in their expressions of dissatisfaction. It would seem that a good measure of group maturity would be to determine whether or not requests for package answers decrease in number during the course of the day.

Rivalry for Leadership: the Monopolist.—Rivalry for leadership was another obstacle to group progress. Sometimes this competitive striving was fairly obvious, as, for example, reacting with hostile comments to whatever was said by the leader. Unconscious rivalry undoubtedly existed, but was much more difficult to detect. The monopolist, the person who tried continuously to dominate, to assert his authority, or to call attention to himself, offered the greatest challenge to leadership and also the greatest threat to the feeling of unity in the group.

Fortunately, the monopolist posed a serious problem in only two groups. Worthy of note is the fact that the leaders of both groups employed similar techniques in handling the problem member.

In each of the aforementioned groups one person attempted to monopolize. In each instance group members reacted with hostility and resentment. One of the leaders felt that the dominant individual aroused hostility by provoking anxiety in the group through attempts at self-revelation. In the other group, the monopolist seemed definitely to be engaged in rivalry for leadership. He acted as if he knew more than the others and continually tried to impress the group with his importance. Both leaders allowed group hostility to reach a crucial point before deliberately letting the group handle the problem member. This method was successful apparently because of the need to belong and the fear of being excluded from the group. Interestingly enough, when one of the leaders attempted to handle the over-talkative member directly and without group aid, he met with only limited success.

Functional Rôles.—One of the most enlightening perspectives on the group-discussion process is provided by the idea

that the members of a group tend to play certain kinds of rôle in the activity, that they tend to assume postures and attitudes that very often have their counterparts in social life. For example, one observer, reporting on the group that was locked in the struggle between traditional and modern education, picturesquely described the establishment of a status hierarchy in which one member played the rôle of crusading district attorney fighting for progressive, permissive teaching, and cross-examining the obstructionists. Other members played such rôles as elder statesmen, brain-truster for the new movement, and counterrevolutionary. Another observer spotted functional rôles which she variously described as evaluator, critic, capitulator, identifier with scapegoat, pragmatist (reality tester), bright-idea suggester, interpreter, and good group member facilitator. The leader should be aware of these functional rôles and be prepared to utilize them in facilitating and coördinating the group's activity.

How Far Shall We Go in a One-Day Institute?—The biggest issue confronting the leaders was the question of how much affect can be safely stirred up in a one-day session. How far do you go in such groups, how much anxiety can you induce in so short a meeting time, and how much could be resolved if it were elicited and analyzed, are certainly moot questions. Despite our goals, the tendency to intellectualize and an inability to discuss subjective reactions were clearly evident.

When a painful point was reached in the discussion, the defense of intellectualization would come to the fore. Outbursts of hostility were often regarded as threatening and retreat into the refuge of intellectualism was sought as safer ground. When a person exposed more of his personal life than the group could apparently tolerate, anxieties and guilt feelings developed. Sometimes an individual became uneasy when the group got too close to a personal problem and when this happened, redirection was achieved simply by generalization. Some individuals completely enveloped themselves in a cocoon of intellectualism through the medium of note-taking. Obviously, academic and technical responses represented resistance even to beginning an exploration of feeling.

One teacher neatly summed up her fear of probing too deeply when she stated: "I felt that I was slipping into a subjective attitude toward my problem."

On the other side of the picture there were individuals with a felt need to verbalize their problems, and they resented the maintenance of discussion in the academic realm. Included among this group were some who pushed the psychiatrists as if they were coming to him for individual sessions, causing one to wonder whether there is not a selective factor determining the kind of people who come to these institutes. But actually the majority of those individuals who wished to examine their subjective reactions were those who had tasted the fruits of such an experience either through participation in a previous institute or in a group-therapy seminar. These members sought further understanding and yet did not expect solutions to their problems. There was no doubt that when a group was able to look at their own reactions to problems, there was greater ego involvement with consequent rewarding and satisfying experience.

One might ask how much trauma can an individual experience in these groups. Psychiatric opinion is that the possibility of such trauma is distinctly present in psychologically vulnerable individuals. A self-weeding-out process may be operative in some of those members who do not return to the group. However, it was felt that skillful leadership could handle such situations.

It is interesting to note that psychiatric opinion was divided on this matter of how deep we shall probe in a one-day institute. For example, one psychiatrist felt that the most profitable discussion could be focused on an objective evaluation of another's relationship rather than on one's own reactions. He justified this point of view by stating that one does not long discuss some one else's situation without bringing one's own feelings and reactions into the picture. In contrast, the opinion was voiced that not quite enough challenges were offered to the participants' stereotypes and platitudes and that some shock experiences might have been far more beneficial than the free-roving, conflict-dodging type of talk that predominated.

However, this apparent difference in psychiatric opinion

probably can be understood in terms of the varying backgrounds and personalities of the psychiatrists and the varying composition of the groups. The chief guiding principle can be stated to be that the group leader goes as far in the direction of anxiety-charged themes as a given group appears ready to deal with them constructively.

Value of the Institute.—Objectivity in determining the value of this institute, with its new orientation grounded in group dynamics and group therapy, is not easily attainable. The post-meeting evaluation sheets completed by the participants are one source of usable data. One hundred and twenty-five participants filled out these sheets, with 49 abstaining. (Many of these were the drop-outs who did not return in the afternoon.) Over 91 per cent of those who gave their evaluations rated the institute as satisfactory or very satisfactory, while the remainder expressed dissatisfaction.

From the evaluations of the participants, it was apparent that the main benefits obtained were primarily increased knowledge and understanding plus an experience that had therapeutic implications. There was no doubt from the comments offered that the institute did provide food for thought, a brief experience that was a sort of appetizer, stimulating further explorations in the back-home situation. They had a chance to express, get constructive criticisms, as well as think about the rôle that they themselves play in interpersonal relationships. In addition, opportunity was provided for meeting with a mixed group of varied backgrounds and experience whose contributions were valuable because problems were presented and analyzed from many different viewpoints.

Many participants expressed an appreciation for what they called an experience in group dynamics. There seemed to be an intense fascination in observing how the leader encouraged the operation of the democratic group process. Amazement was voiced on how a relatively permissive atmosphere quickly resulted in a free interplay of ideas. Some marveled at the way the leader permitted expressions of hostility and how these drives were constructively channeled. Others were impressed with the various group methods and techniques utilized to increase communications. Participants gained valuable insight into the dynamic forces operating in the

group process, and a few stated that this increased understanding would help them contend with emotional forces in other groups.

Recognition that educators have many problems in common were stated by a majority of the participants as the institute's main value to them.

It should be clearly understood here that teachers were essentially recognizing the universality of basic emotional problems. This recognition had a comforting effect and served to dilute guilt feelings over their inability to handle some of these problems. It was obvious also that the group discussions had a cathartic effect. The repeated expressions of gratitude, in the post-meeting evaluation sheets, for the opportunity to ventilate their problems substantiate the fact that this experience had cathartic value. One teacher makes this insightful comment, "The teachers seemed to get relief in talking about this problem. Maybe this is the reason for such institutes." A few participants affirmed that the institute helped them greatly, but could not tell how they were helped except that they felt more relaxed. One teacher stated that he gained a greater understanding of himself and of his basic problems. Finally, this remark by one of the teachers seems to reflect the current of feeling among the participants: "I just noticed that I feel less irritation about the problem I brought up this morning. No one has told me what I should do, but something has happened that I rather value."

Recommendations.—Over the past three years an idea has been logically developed by the Massachusetts Association for Mental Hygiene that apparently has great merit for improving mental-hygiene practice both in school and in community. Each year has seen succeeding institutes profiting from previous mistakes. It is clearly recognized that the final answer has not been found to the basic issues raised as a result of a specified philosophy and framework of reference. Furthermore, there is still room for improvement in the planning and conducting of these institutes. It is necessary to remain constantly alert to the deficiencies and assets with a view toward diminishing the former and increasing the latter. The following recommendations point up some of the areas of concern in which worth-while energies may be devoted to bringing

about greater assurance that mental-health objectives will be realized.

The big question is, How much change do these one-day institutes accomplish? It is hoped that the institute contributes to a modification of feelings and attitudes, with a consequent improvement in interpersonal relations, but to date no attempt has been made to assess scientifically the change potential of the institute. Some idea of its immediate impact can be garnered from the post-meeting evaluation sheets and the reports of the observers. What the enduring impact is, however, is little known. To some extent participation in a group-therapy seminar is a rather crude and limited measure. In order to determine whether the institute has brought about change that perseveres, a systematic follow-up should be conducted about six months after the sessions are held. All participants should be canvassed at this time for their reactions to the institute. Such a survey would provide us with informational material that would be both interesting and useful.

An effort to explore the question why people rate the institute the way they do might prove to be a rewarding endeavor. People come to these meetings with all sorts of expectations and these may be fulfilled completely, or in a part, or not at all, with subsequent frustration and disappointment. Thus, there would be two aspects to this investigation: (1) with those that expressed satisfaction, to inquire why they were satisfied; and (2) with those that expressed dissatisfaction, to inquire why they were dissatisfied. Such data would certainly be important in future planning.

Two research possibilities that deserve recommendation include an exploration of subgroup phenomena and a more careful study of leadership. Subgroup phenomena could be studied from the point of view of their relation to the composition of the group, their relation to drop-outs, and their relation to group productivity. Leadership studies should include an appraisal of the impact of the leader upon the group and a documentation of leadership techniques and practices and the situations in which their employment was successful or unsuccessful.

^aSince the planning committee has twice rejected the idea

of a two-day institute because of certain complications involved, it is recommended that discussion periods should be extended to include two-hour sessions rather than the usual one-and-a-half-hour periods. A number of participants complained that it is difficult to discuss emotional problems in a new group and that it takes time and patience to get a group to face the reality of their emotions. It is unfortunate also that just as groups were beginning to develop a "we" feeling and a fruitful sharing of experiences, the time for the discussion sessions had run out.

An expansion of group-therapy seminars as a supplement and complement to the institute experience is heartily recommended. Change, to be effective, must come about through cumulative experience. The seminars offer an opportunity for individuals to realize the significance of the group experience in terms of shifting from the intellectual to the feeling level. A seminar also enables the leader to explore individual problems and even to offer some interpretation. The post-meeting evaluation sheets provide us with sufficient evidence that a number of participants could profit from such seminars.

Finally, it should not be forgotten that during the past three years a number of seeds have been planted which are just beginning to take root in school and community. Ultimately, our basic concern should be focused on the question of how can we get action programs beyond the institute and seminar levels. If we are really to have effective, preventive mental hygiene, then there is a need for pervasive programs that permeate both school and community. The future appears hopeful and contains many great challenges.

WHEN PSYCHIATRIST AND PATIENT TALK TOGETHER *

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I AM glad to have the opportunity to make some remarks about psychiatry, how psychiatry works, how psychiatrists help their patients, and what goes on when the psychiatrist and patient talk together. I know the psychiatrist is both feared and admired, and I should like to take away part of the mystery that surrounds his work. Our motto will be: No damask curtain around the couch.

We should keep foremost in mind that the psychiatrist is first of all a physician, a healer, one who treats sick people, one who tries to restore the sick to health. Like any other medical practitioner, he sees people who have pain, who are suffering. Those people who consult a psychiatrist come for relief of this pain and suffering as much as those who go to any other doctor of medicine.

Now, how do these sick people who go to a psychiatrist describe their pains and suffering? One has severe headaches; another has periods of painful tension or nervousness or anxiety or panic; another is afraid to go out into the street alone. Some come because they have stomach pains, or because they eat too much or drink excessively. Others are depressed or unhappy or dissatisfied in their work. Others can't get along with their wives, or husbands, or parents, and are irritable, moody, and confused. Others feel inadequate, or have difficulties in their sexual relations. All of these people have pain and suffering in one way or another. Their pain hurts like any other pain; there is no such thing as an imaginary pain or a pain that is "all in your head." Pain hurts—whatever its source.

Frequently we see people who put off going to a psychiatrist because they feel that a stigma is attached to psychiatric

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treatment. Recently a man returned to a Veterans Administration mental-hygiene clinic, having been there two years before for one visit only. He could not bring himself to come back then, but waited two years, and during this time he continued to suffer with nervousness, tension, mental confusion, difficulty in studying, and many aches and pains. Out of desperation he finally returned. After several weeks of treatment his fears about psychiatric treatment and the psychiatrist were allayed, and he realized his delay of two years had caused him much needless suffering.

An illness involving feelings, emotions, thoughts—a disease or a *dis-ease*—is an illness like any other illness, and the appropriate treatment should be sought, and sought early.

Now for some brief comments about psychiatric treatment. What does the psychiatrist do to relieve pain and suffering and restore the patient to health? He has all the medicine and other therapeutic weapons available to the medical profession. He uses medicine to relax or to stimulate. He utilizes the various shock treatments when they are indicated. These and other physical methods of treatment you have probably heard about. It is around the psychological methods that mystery has gathered. I would like to spend the remainder of the time describing what goes on in psychotherapy.

Words can heal. Words can kill. We use a kind of shorthand, of course, when we say *words* kill or heal. It is the person's total reaction to the meaning or context of the words that kills or heals. Language is acquired very early in life, during the first two years, and words are given powerful sub-surface, often magical, meanings which can do damage.

Here is an example: A physician once told a patient that her doctors finally understood her disease. I saw the patient soon afterward because she had become upset and anxious. What had disturbed her was that she had been told she had a *disease*. To her, disease meant only one thing—venereal disease. She was upset because she thought the doctors would think she was promiscuous.

Squarely in the center of psychological treatment is the act of communication, the interaction and exchange of thoughts and feelings. Yes, considerable mystery is connected with psychiatry, and part of this mystery is based on the solid fact

that psychotic and neurotic behavior are strange and not easily understood phenomena, phenomena familiar only to clinicians who study and work with them.

While the content of psychiatry may be unfamiliar, its form or its structure, as presented in psychiatric examination and psychotherapy, need not be strange to any one. That aspect of psychiatry is an act of communication, an exchange of thoughts and feelings between people, an interpersonal relationship similar in mechanism to those we all engage in every day.

Consider this example: A young man comes to a psychiatrist and reports certain feelings of uneasiness in restaurants and other public places. This symptom, and others, are elaborated, with a minimum of questioning by the doctor, and the patient may be asked to tell something of his life's story.

Now, in what ways is communication going on? In what ways are messages passing back and forth? What is being transacted? What information is being exchanged? I am going to describe some of the levels on which communication is involved in the psychotherapeutic process.

1. First of all, the aggregation of symptoms may resemble the pattern of a recognized psychiatric illness. An identifying label or diagnosis can then be attached to the case. The physician gives meaning and significance to the presence and arrangement of certain symptoms.

2. Secondly, considering all the productions of the patient, the psychiatrist attaches significance to the patient's gestures, intonation, facial expression, grooming, bearing, grammar, choice of words, and so on. Everything the patient does can be understood to express something about his character and his defenses against anxiety. Perhaps you have noticed the ways people walk down a corridor—some near the wall, as if they were about to lean on it; others straight down the center. The way a speaker strides on to the platform can be revealing. This *non-verbal* communication laymen often tend to neglect. The psychiatrist cannot neglect it.

3. What the patient fails to mention may have special importance. Most of us avoid talking about events about which we are ashamed, or fearful, or sensitive. In telling our life's story, we "forget" episodes that gave us mental pain. Freud,

of course, first recognized the significance of these lapses and utilized this observation about gaps in a patient's story to develop the methods and principles of psychoanalysis.

4. What does it mean to come to a psychiatrist? This is another area in which communication prevails. What does it signify to the patient in terms of guilt, loss of self-esteem, shame, time, money, family relations, and so on, to undertake psychiatric treatment? The answer will be found in all the things the patient does and says and feels during and after the treatment sessions. The personal and social consequences of coming for psychiatric treatment are a major dimension of that treatment.

The patient directly or indirectly asks for help. He invests the physician with a mantle of power and authority, and frequently has magical expectations regarding treatment. Secretly he expects to have something done *to* him, not realizing that he will have to work hard on himself if he is to get well.

5. Communication is not a one-way street. The physician is communicating with his patient also. By considerate listening, he conveys his acceptance of the patient as a person and of the patient's verbal and non-verbal productions. This does not mean that he approves the content of these productions, but that he considers them worthy of attention. A demonstration and an extension of this acceptance are given when the psychiatrist arranges to see the patient in regular sessions for months or years. When a physician who ordinarily sees several patients in an hour devotes such a large block of his time to a single patient, it becomes a significant cultural fact.

6. In numerous other ways—tone of voice, facial expression, type of question, and so on—the psychiatrist demonstrates his interest in the patient and his commitment to the patient's welfare. The patient's response to this handling comes to occupy the center of the treatment stage. Emotional reeducation, or a corrective emotional experience, is made possible by the professionally neutral behavior of the therapist.

7. There is mutual communication between patient and psychiatrist in yet another way. "Unconscious" speaks to "unconscious." There are reactions, feelings, values, and assumptions of which we are not ordinarily aware and we speak of these as unconscious. These unconscious evaluations

and emotional trends the psychiatrist is especially trained to detect, and he uses his own unconscious processes as an investigative and therapeutic tool.

As the patient tells his story, the psychiatrist reconstructs the pertinent events in the patient's past life, filling in gaps and recognizing psychological trends. In the case already mentioned, of a young man who felt uneasy in public places, it may have become apparent that he had strong tendencies toward self-display, and that his ability to control these exhibitionistic impulses was threatened whenever he was in a group, as this increased the strength of the unacceptable impulses. The threatened emergence of forbidden impulses produced anxiety. The psychiatrist would gradually point out these impulses to the patient, and together they would explore the reasons for the intensity of the impulses and the patient's inability to deal with them without anxiety.

I have indicated ways in which there is communication or verbal and non-verbal exchange in the doctor-patient relationship of psychiatry. A way to show that psychiatry is a communicative endeavor and collaboration is to ask the questions: What does the psychiatrist tell his patient? What does the patient tell his psychiatrist? Obviously more is transacted between them than words. There is a transfer to the psychiatrist of attitudes, fears, loves, and hates distilled from the patient's life and representing his current methods of dealing with people. There is an emotional transaction between patient and doctor via unconscious routes. The physician gives emotional support and acceptance by listening and by apportioning regular periods for treatment. He points out pertinent behavioral trends and reactions to the patient, and interprets to the patient the meaning and significance of the behavior.

The experience of communication in psychiatric treatment enables the patient to improve his own ways of recognizing and expressing his feelings and thoughts. He comes to see the powerful rôle of communication in all interpersonal relationships.

THE CASE-WORKER'S PARTICIPATION IN PREPARATION FOR TONSIL- LECTOMY IN CHILDREN *

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TONSILLECTOMY, usually the first operation of childhood, fairly common in early childhood, and elective in the sense that it can be planned for, offers a life situation involving anticipation, separation from parents, and induced loss of consciousness, loss of a bodily part, and pain. The effect is often apparent in childhood behavior disorders.

Studies on the preparation of children for tonsillectomy experience have been conducted in various parts of the country.¹ Experimental work being done by the Pediatric Department of the Albany Medical College and Albany Hospital, under a grant from the New York State Department of Health, seems to have been developed along slightly different lines, which we would like to report herewith.

The working group consisted of three pediatricians, an anesthetist, and a social worker, all of whom are psychologically oriented. The study was confined to children between five and eight years of age. This age range was chosen because at five most children have had the experience of being separated from their parents by starting to school. This experience is an important step in each child's development and, if unsatisfactorily met, may have a profound effect on future separations. Nine was set as the upper age level since adolescent problems would not yet have appeared. The group engaged in the study recognized that this was an arbitrary limitation, not representing the child's social or emotional maturity level, but roughly circumscribing the latency period.

* This study was conducted in coöperation with and with the support of the New York State Department of Health.

¹ See, for example, "Psychic Trauma of Operations in Children," by David Levy (*American Journal of Diseases of Children*, Vol. 69, pp. 7-25, January, 1945), and "Observations on the Emotional Reactions of Children to Tonsillectomy and Adenoidectomy," by Lucie Jessner and Samuel Kaplan, in *Problems of Infancy and Childhood* (New York: Josiah Macy, Jr., Foundation, 1949, pp. 97-117).

Prior to the actual study of the child in the operative experience, a basic study of children in this age range from one school district in Albany was made by the social worker. The district might be said to serve families from the middle-class group. That is, there were no slums and no elaborate homes. One hundred children were seen and their mothers' descriptions of their behavior were recorded.

For uniformity, the interviews followed a questionnaire pattern, though not the form. Birth and development, size of family, and child's place in family were noted; also, willingness to get up in the morning, interest in food, interest in dressing himself, ability to make friends, enjoyment of school attendance or new experiences, reactions to a new baby or to death in the family, any separations from his parents, dreams and nightmares, self-comforting behavior, and aggressive behavior. The results of this basic study have been recorded elsewhere.¹

With the knowledge of children's behavior at each age in the original study, it was possible to form a picture of the average child, if such there be, in this age range on which could be superimposed the reactions to the operative experience.

Another feature in the Albany study was that each child was visited in his own home by the social worker prior to admission to the hospital. Preparation for this visit came from the operating surgeon at the time of the office call. These home calls were made not earlier than a week in advance of the hospital admission. The same sort of information was sought from the mother about her child as was recorded in the original study.

Seeing the child in his own home setting was revealing of unconscious attitudes in both mother and child or siblings toward one another. It also allowed observation of consistent or irregular handling of the child.

Rejected children might make desperate pleas for the worker's attention under the encouragement of being the person the worker had come to see. The mother's attitude was quickly revealed when she threatened to banish the chil-

¹ See "Emotional Reactions and Behavior of Children in the Home," by Ruth Winkley, Katherine Jackson, Otto A. Faust, Marjorie F. Murray, and Ethel G. Cermak. *Journal of Pediatrics*, Vol. 35, pp. 476-81, April, 1951.

dren from the room if they did not "leave the worker alone," or insisted on the children's keeping still in order that she might enumerate some of her own anxieties.

On a few visits, when the mothers had obvious preference for siblings other than the patient, a good deal of time had to be spent listening to material about their "good" child, their invalid child, their beautiful child, or their "smart" child, before the necessary information was forthcoming about the patient.

This required an understanding of the mother's needs. At the same time it was necessary for the patient to be given some feeling of security in the worker without, if possible, stirring up in the mother greater feelings of rivalry, rejection, or punitiveness.

Visits to the home proved to be of increasing value as the social worker discovered the kinds of thing that made both children and mothers anxious about the forthcoming operation. As might be expected, the mother who had been traumatized as a child by her tonsillectomy and subsequent operative procedures, could not but show the residual tensions from her experience and these, without intention, could be transmitted to the child, so that he might enter the experience with a good deal of unaccountable fear.

Although in the experimental study it was permissible for the mother to stay with her child throughout the whole period, sleeping in the same room with him, when a mother betrayed so much anxiety that she realized she would be worse than useless to her child, she was understandingly treated and there was no urging her to do that which would create added tension in herself and in the child. There were a few mothers who were unable to express their anxiety overtly, but were so vehement about being needed at home that they were accepted at their word, with no pressure on them to accompany the child to the hospital.

The majority of mothers, although inwardly fearful of how they would react to the whole process, nevertheless were determined to accompany their children. A very few displayed a good deal of feeling of self-sacrifice and martyrdom.

By and large the great majority of the mothers who accompanied their children were very grateful for the op-

portunity. As knowledge of the possibility of staying spread through the community, more and more parents demanded that their children be in the study, so that they could accompany them.

Study children were admitted to a two-bed room, and, when possible, boys were admitted together and girls together. This seemed less difficult for an only child or for those who had siblings of the same sex only, especially those who had had no sex instruction.

While learning the kind of person each particular child was, it was also possible for the social worker to describe to the child the size of the hospital; what he would see as he entered the door; the ride in the elevator; what the children's ward looked like; the fact that the residents and nurses are dressed in white, which may be a new and sometimes frightening experience to children; a description of the hospital bed, which can cause a good deal of consternation on the part of a child who has graduated from his own crib to a youth bed and fears that he is being made a baby of.

Children were encouraged to take their own pajamas so that they could feel they had something that was part of themselves and their home atmosphere. The necessity for undressing in the daytime was explained, and the physical examination, like that in their own doctor's office, was anticipated. It is almost a truism that children dislike needles. For this reason all medications and treatments requiring needles were reduced to a minimum.

Rectal temperatures gave place to oral temperatures. Enemas were dispensed with. The blood sample was a necessary routine procedure and the fact that a child could watch a little bead of blood going up into the glass tube interested him so much that the slight prick which preceded it was quickly forgotten by his participation in the process, which had already been explained.

Children were encouraged to bring color books or favorite toys, and were especially urged to bring the teddy bear, doll, or favorite truck that always slept with them.

It was necessary for the social worker to be on the watch for the occasional loose tooth, as each child was assured that he would not be told any falsehoods and that the whole pro-

cedure would be just as described. It was important that no child should suffer any operative procedure not anticipated with him ahead of time.

The child was told that at supper time he would eat from a tray and could engage in activities with other children in the playroom, including television. The doctor who was going to help him go to sleep the following day would come to see him and tell him all about it.

The anesthetist always visited the children on the afternoon of admission, showing them her green costume, letting them feel the mask, turn it over, try it on, and also smell the preparation that was going to put them to sleep, which, as described by one of the children, "was something like mother's nail polish."

Each child was told that his tonsils were not important, like his tummy, his eyes, or his nose. He would have a very sore throat after his tonsils were out, but he was assured that he would not feel anything while they were being taken out; that each succeeding day his throat would feel increasingly better; and that the social worker would be back to see him about ten days after he got home and he could tell her just how the whole thing had gone.

It was decided that ten days after the operation was a better time to visit than one week later, as in ten days the child has usually recovered to the point where he is feeling completely well and under ordinary circumstances engaging in average activities. At this visit it was possible to learn how loath the child might have been to recover; how much he hung onto being the sick, complaining child who was waited on, had to be fed, given presents, and the general attention of the whole family; or how independent he was of the need to control by being sick, irritable, and babyish. This visit allowed the social worker to observe again the mother-child relationship.

Some mothers, without conflict, had allowed their children to set their own pace for resuming normal activities and had been understanding, but firm, when imposing necessary limitations. Others kept their children inactive and dependent far beyond the period prescribed by their surgeons. A few openly confessed threatening to have the tonsils put back if

the child continued irritable and cross. In one or two instances, mothers anticipated taking a special trip or outing because they had "been through" so much.

On this visit particular attention was paid to the kinds of dream the child had had during the preceding week. Many children had frightening dreams and nightmares or talked in their sleep directly after the operation. Most of these children had had bad dreams before, and as recalled, many were dreams of attack, but did not persist. Some children could recall no more than a dizziness and everything green, which was a reality recollection, as surgery walls and the uniforms are green.

Although some new self-comforting behavior appeared right after the operation, it was usually a temporary displacement of former behavior and the former behavior was reverted to in a short time. This kind of behavior had to be watched for rather carefully by the social worker, as often the mother was embarrassed to make such observations herself.

This seemed to be true of masturbation. Although some children were going through masturbatory motions at the time of the first visit, caution was taken then not to emphasize this if the mother did not herself recognize it, lest she become upset and threatening toward the child. By the second visit it was possible to inquire matter-of-factly if there had been any increase in masturbation during the period of illness. In some instances, this produced a complete denial, an evasive attitude of never noticing. Some mothers took it for granted and could report without difficulty some increase in masturbation while the child was ill.

Another self-comforting device seemed to be nose-picking. The social worker herself made the discovery that many children whom she had not seen picking their noses before were doing it quite a good deal at this visit. Some of it had become rather extreme, and in one or two cases the children had to be given special treatment as it had caused rather severe hemorrhaging and scabbing. It was interesting to note that often the child who had been a thumb-sucker gave this up at the time of his sore throat and adopted nose-picking as a substitute, but when his throat was healed, returned to his former thumb-sucking.

To make quite sure that some of the behavior that appeared directly after the operation was transitory and not permanent, another call was made two months later. In almost every instance the transitory or accentuated behavior that had appeared at the time of the operation had diminished or ceased and had not recurred.

Another benefit of the call two to three months later came about through the strengthening of the relationship between child, mother, and social worker. Progressive meetings allowed for better acquaintance each with the other. It permitted the mother who had faced preparation for the operation, the operation, and the convalescent period, to discuss the child with a great deal more relaxation than on either of the two former visits. Information about the child's past behavior and experiences often came to light which the emergency of the operation had blotted out on the two former calls.

For the most part, instead of obscuring the picture, whatever was added to the composite picture by the third visit confirmed the impression that most of the children, despite whatever traumatic experiences they had had in the past and whatever transitory symptoms they may have displayed, had been able to get feelings of accomplishment and personal triumph over going through the operation satisfactorily when it was carefully and truthfully anticipated with them.

As examples of how children behaved despite parental fears or their own anxieties, we present four cases:

One child had always been afraid of closed-in places and heights, yet, knowing that he would ride in an elevator to the children's ward and operating room, went through this experience without a trace of anxiety. With him the whole operative procedure was so successful that when he faced another operation several months later without his mother's being present, he accepted that experience with no hesitation or ill effects that could be observed. He did not lose his timidity at being left in a car by himself, but apparently did not look on the shut elevator or its rising as fear-producing factors reminiscent of his earliest traumatization in this area.

Another child already severely traumatized toward hospital and separation behaved in the following manner. At the age of fifteen months, when his mother was having a new baby,

he was suspected of having measles. The family were in Germany, where measles is isolatable. He was hospitalized for ten days without being able to see either parent. He had had severe night terrors ever after.

When visited prior to tonsillectomy, he was an anxious-looking little fellow who spoke in a babyish manner. Much of his speech sounded like gibberish, although when understood, he had an extensive vocabulary, was alert and observant. Subsequent to the operation and the lessened throat congestion, his speech lost its indistinctness and by the two-month call he was easily understood. He was also showing a new venturesomeness and independence, climbing and swimming as he never had before. His facial expression had lost its tenseness. His nightly screaming had ceased except for two occasions when he was in strange surroundings.

A third child was very difficult for the worker to approach on the first visit. Her mother and grandmother were present at the interview, replying with caution when addressed. The child evidenced very irregular handling, was silly and attention-getting, turning somersaults and diverting the subject continuously. In this case it was possible only for the worker to tell her mother the procedure and let her interpret this to the child as she was able.

It was to be expected that this child, who had not faced any of the steps as described, would have a difficult time when it came to the reality of the situation. The night before the operation and the night after, the child slept very little and needed a sedative. Her behavior in the hospital was in character, but showed that she had absorbed more of the preparation than had been realized. Her chief complaint was that her bed had no sides, and it was necessary to move her to a bed that had before she could be quieted. Subsequent visits did not elicit any manifestations of real trauma from her experience, although she enjoyed her negativistic complaining about the bed, the food, and the television programs.

On the last visit her mother was able to discuss the child's orthopedic difficulties, which had kept her immobilized from thirteen months of age for a long period, so that she had been held back in walking, although developing normally in every other way. It was learned that the child had been over-

pampered because of this, but at the same time held up to rigidly high standards of training. On this third visit, the child was composed in manner, speaking much more directly to the worker and to her mother, and had lost the need for "showing off."

One little boy surprised every one with his hospital and subsequent behavior. When first visited, he had a violent temper tantrum, kicking, biting, and scratching his mother because she turned the radio off. He had had months of infection with high fever and sore throat. His father and he had been inseparable companions, but his father had gone to a new job. He had two sisters, seven and ten years older, who teased him excessively, and he retaliated with biting and kicking. His mother was exhausted from trying to fill his demands and be a play companion in her husband's absence. At school, while capable of doing superior work, he, at the end of the pre-primer year, was just becoming confident enough to draw his chair into the circle with the other children. He had never been able to ask for supplies and would sit with his milk bottle before him rather than ask for help in getting the cap off.

At the time of the first interview, he told the worker that he would not sleep in the room with any one else and wanted the playroom all to himself.

He referred to himself in the objective case—"Me do it," "Me go," and so on; his mother said this had been going on for over a week. As his mother conversed with the worker, he interrupted frequently with a high, silly laugh. Yet, before the worker left, he had come to sit on the arm of her chair and brought armloads of toys for her to admire.

When he arrived at the hospital, because of crowding, he was put in a room with a little girl. He accepted this arrangement at once and enjoyed himself with the other children in the playroom. His only protest was over using a bedpan, and he insisted on having his pajama pants on when he went to the operating room. This being allowed, he went through the whole process satisfactorily and had no nausea when he emerged from the anesthetic.

On the ten-day visit, he hid and the worker searched until

she found him under the sofa. This play pleased him immensely and he again produced toys and chatted pleasantly when addressed, but was able to play quietly while his mother was talking. The "Me do it" had entirely disappeared.

By the third visit, he showed still greater improvement, speaking clearly in well-formed sentences. He kicks his sisters occasionally when they quarrel, but is far less irritated by them than formerly. On the whole, he has gained a surprising amount of confidence in himself as a person.

This study was a continuous learning experience for all those engaged in the research. It was constantly necessary to be observant of symptomatic behavior demonstrating anxiety, and to attempt to understand the origin of this anxiety. This was particularly true in working with the youngest group, whose language limitations do not allow for more than one definition for a word. Early in the study the word "mask" seemed with an occasional child to mean only the grotesquery of the Halloween mask. We have all seen anxious young children at Halloween. This was constantly anticipated thereafter.

Also, despite the best efforts of parents and all the people engaged in the undertaking, the confidence that children place in one another is not to be taken lightly and needs to be watched and cleared up whenever possible. One boy who had been told only that babies come from the hospital asked if he would bring home a baby. Another was sure that his abdomen would be opened, on the statement of one of his playmates who had had a hernia operation.

A few children who had been bed-wetters stopped after the operation. It is impossible to interpret sudden cessation of such behavior with so little information on the child's total development and handling. It is true, however, that in many cases parents threaten or bribe without realizing that they are doing it.

To say that any or all the cases were completely successful would be an overstatement in the light of the small body of knowledge at hand for each child and his family, and without following each through future life experiences.

Whereas the study is not yet concluded, it suffices to say

that parents, the hospital personnel, and the surgeons have found the operative procedure to go more smoothly generally than in other situations they have encountered.

In such a study nothing is really conclusive short of a complete study of each case and a rather full evaluation of the total family, plus the opportunity to follow the child through future life experiences. Nor can it be proved that any single factor in planning for the operative experience took precedence over any other.

Whatever ease in meeting the tonsillectomy experience the children showed came from the combined efforts of all concerned to learn what is anxiety-producing and to prevent its occurrence whenever possible.

The project does, however, demonstrate the possibilities of preparation for operation in a hospital that does not have extensive psychiatric services for children, but in which psychologically sympathetic workers can be cognizant of symptoms and strive to alleviate fear-producing situations.

SOME PROBLEMS OF MENTAL-HYGIENE RESEARCH WITH CHILDREN *

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IT is generally agreed that much basic research is needed before mental hygiene can ever begin to accomplish its purpose. Most of the theories of personality formation in vogue to-day have a genetic orientation and stem from the belief that events in childhood shape the personality of the adult. The search, therefore, is for preventive measures which, when applied early enough, will be effective in reducing the incidence of mental breakdown.

In our present state of knowledge of mental hygiene and personality development, we rely mostly upon "after the facts" evidence. Whether or not evidence obtained in this manner sheds genuine light on the factors that contribute to mental breakdown can be ascertained only by submitting such evidence to experimental tests. The purpose of this paper is to discuss some of the problems and obstacles to basic research in this area. In the interest of clarity, the discussion can be divided into the following areas of difficulty:

1. The definition, isolation, and control of significant variables.
2. The assessing of the efficacy of preventive measures.
3. The inadequacies of present-day theories of personality development.
4. The problem of support and coöperation from educational institutions.

The Definition, Isolation, and Control of Significant Variables.—Although the literature is replete with such terms as "emotional security," "rejection," and "bio-social inadequacy," to name but a few, their isolation and definition are a much more difficult problem. Workers themselves disagree on

* From a paper delivered at a symposium on "Problems of Mental Hygiene Research," at the convention of the Texas Society for Mental Hygiene held in Fort Worth, April 6 and 7, 1952. The symposium was sponsored by the Hogg Foundation for Mental Hygiene.

the definition of these terms. Additionally, we have the problem that anxieties do not all have the same overt manifestations. Thus, one person may react to anxiety by aggressive behavior while another may react by withdrawing completely. Experimentation involves the manipulation and control of known variables. That is, we know or suspect that the imposition of certain controls or the manipulation of certain variables will favor the possibility that certain phenomena will occur. It is difficult to proceed on any hypothesis of causality when the suspected causal agents are as yet so nebulous and ill defined.

The Assessing of the Efficacy of Preventive Measures.—Once the variables have been isolated and defined and methods of control have been worked out, there arises the question of determining the effect. Let us assume, for example, that a group of variables, such as class discussion of problems plus individual counseling, will be of aid in the resolution of present problems and augur well for future adjustment as adults. Theoretically, we could take one class in school and use these variables to the fullest. As a control group, we could use a class of equivalent composition that did not experience these variables. Then we could judge the effect.

But the question arises, How long do we have to wait before we can come to any conclusion? It may be years. The task of following these classes for the next twenty-five years is tremendously expensive and involved. Yet how else can we be sure that this "psychological vaccination" really works? It is unfortunate that such studies were not started years ago, for the results might now be available to the mental-hygiene movement. As an example of the value of such a genetic study, we have only to look to the Terman studies of gifted children. These studies have provided tangible information about intellectually superior children and have served to dispel some of the persistent myths concerning the mental stability of the gifted group.

The Inadequacies of Present-day Theories of Personality Development.—Since, as has been said, most of our theories of personality development are genetically oriented, it would seem only natural that the research worker should look to the field of child and developmental psychology for aid and information. So far there has been much disappointment.

It is unfortunate that the only integrated theory of personality development in wide use to-day—namely, psychoanalysis—is at the same time composed of constructs that are difficult, if not impossible, to submit to experimental validation. Much of the research in child psychology has been from "behavior to context" rather than from "context to behavior."¹ This is understandable, if lamentable. It is much easier to gather data from cases and look back than to institute specific situations and predict what the behavior will be. There is by no means any agreement among child psychologists as to how to achieve the goals of mental hygiene. In fact, the controversial material put out by rival "experts" has served to confuse the general public and weaken the position of psychology in the mental-hygiene movement. We have only to look at the controversies raging about such child-rearing practices as breast-versus-bottle feeding, emotional display versus control, and so on to see why the layman is partially justified in invoking Shakespeare's line, "a curse on both your houses."

The Problem of Support and Coöperation from Educational Institutions.—In all research, the quest for subjects is paramount. In fact, the very nature of the data is determined by the types of subject available for study. It is only natural that avid research workers should turn to the school systems of the nation, for they are a prime source of subject material. The schools have the children for long periods of time. They can be followed through the years. Different socio-economic groups are available. These and many other factors make the school attractive for research, but unfortunately in most cases harmonious relationships are lacking. Barker² has pointed out that while social agencies, universities, and governmental agencies are the most frequent supporters and sponsors of research relating to children's behavior problems, the public schools rank fourth and comprise only 16 per cent.

In defense of the school system, it should be recognized that they are beset with a host of problems. They have a curriculum to follow and they are swamped by a host of graduate

¹ See "Methods of Child Psychology," by John E. Anderson, in *Manual of Child Psychology*, edited by L. E. Carmichael. New York: John Wiley and Sons, 1946.

² See "Child Psychology," by Roger Barker, in *Annual Review of Psychology*, Vol. II, edited by C. P. Stone and D. W. Taylor. Stanford, California: Annual Reviews, Inc., 1951. pp. 1-22.

students with questionnaires, some of them good, some worthless, all of them taking up much time. They have to placate irate parents who object to the use of their children as "guinea pigs," to questions about the child's home life, and so on. As a matter of expediency, much crucial research has been banned from the public schools because it is "loaded"—i.e., it is likely to irritate the parents.

Frequently the school records, inadequate as they are, are unavailable to the researcher because they constitute private information. It is lamentable that many of the parents who bitterly protest any use of their children as subjects will be the very ones who complain about the high taxation burden of supporting the mental hospitals in which some of their own children are bound to be confined because preventive measures could not be instituted. Realizing that educators have many problems and responsibilities, the writer yet feels that mental hygiene is one of those problems and partially the responsibility of the educational system.

The Need for Coöperative Research.—The problem and challenge of constructive, effective mental hygiene involves so vast and complicated an area of human behavior that it is impossible for any one discipline alone to provide the answers so necessary to progress.¹ Because of this, the need for coöperative researches that embrace various disciplines is an absolute "must." One well-designed and executed investigation that considers the sociological, psychiatric, psychological, and educational aspects of a problem is worth more than a dozen inadequate, isolated studies, full of experimental errors, improper sampling, and inconclusive results.

It is only through such coöperative studies that mental-hygiene research can begin to make progress. It is possible that many of the variables that we so glibly bandy about as causal factors will be discredited in the light of future research. If so, new approaches and concepts may have to be adopted. This cannot be done, however, until there exists a reasonable degree of certainty about what we are doing. The elimination of blind alleys is one of the first steps in a constructive mental-hygiene program.

¹ See "The Prevention of Personality Disorders," by G. S. Stevenson, in *Personality and the Behavior Disorders*, edited by J. McV. Hunt. New York: The Roland Press, 1947. Vol. II, pp. 1164-90.

THE INCIDENCE OF FRUSTRATION IN A COUNSELED AS COMPARED WITH AN UNCOUNSELED HIGH- SCHOOL GROUP *

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FRUSTRATION is a spasmodic phenomenon. It is not goal-oriented. It is an outstanding problem in our schools. As aggression, it develops from emotional insecurity. Frustration may be observed in the schools among the failures and those with behavior and conduct problems.

The *problem* in the study reported here was to discover and observe the effect of counseling and therapy on frustration. It was also an observation of the constancy of the I.Q. in a counseled and an uncounseled group with frustration in common. The *method* was to select 100 school failures who came under the classification of frustration, and give them counseling and therapy adequate to their needs; then to select another 100 school failures and problems who were full of frustrations and deny them counseling and therapy of a professional nature. Both groups were from the Dusable High School in Chicago.

Traits and problems basic to the frustrations in both groups were discovered in two ways—through the recommendation of teachers and by personality tests, chiefly the Thurstone and California personality tests.

The Kuhlmann-Anderson test of intelligence was given to both groups at the beginning and at the close of the experiment.

The test revealed that there was a definite rise in I.Q. after counseling. The counseling period was about two years in some cases and only five or six months in others. The prevalence of frustration with traits and problems tended to cause students to block in intelligence examinations. Good counseling and therapy tend to unblock this reserved mental energy.

* Presented at the annual meeting of the American Psychological Association, September 2, 1952, Washington, D. C.

The average I.Q. of the counseled group was 94.6 before counseling and 106.8 after counseling, a rise of 12 points. The average I.Q. of the uncounseled was 97.2 at the beginning of the experiment and 94.8 at the close of the experiment.

When the study began, the counseled group had 15 per cent classified as superior, and 23 per cent below average in intelligence. The majority—62 per cent—were of average intelligence. After counseling and therapy, this group, now reduced to 91, had 24.1 per cent superior, 56 per cent average, and 19.8 per cent below average in intelligence.

The uncounseled group showed a decrease in the superior-intelligence classification and an increase in the below-average classification. At the beginning of the study, it included 18 per cent of superior, 52 per cent of average, and 30 per cent of below-average intelligence. After the experiment, the 79 members still remaining in the group included 12.7 of superior, 44.3 per cent of average, and 43 per cent of below-average intelligence.

It will be noted that drop-outs were more numerous in the uncounseled group, the counseled group losing only 9 students during the time of the experiment, while the uncounseled group lost 21. These drop-outs included the bright as well as the dull members in the uncounseled group.

We made a detail study of 12 traits and problems basic in the frustrations of the two groups. We found five in the counseled and two in the uncounseled group with compulsive mannerisms. These mannerisms are associated with neurotics. Neuroses are diversified and may be varied in handicaps and disabilities. Such neuroses may be associated with the child's twisted pattern of thinking. This often produces a feeling of inferiority which dominates the life of the child.

Kleptomania, as a trait, was found in three of the counseled and five of the uncounseled. This represents more than 2 per cent of both groups. Counseling for this trait is difficult. It depends on training, attitudes, and patterns of life prior to the development of the trait.

Another interesting trait, with many varieties, was dipsomania. Twenty-one of the counseled and 18 of the uncounseled showed this trait. The study here is very important.

because these children represent the future drunkards in the population. Much patience is needed on the part of the counselor in helping these young people develop worth-while substitutes. Dipsomania often represents some unfulfilled need.

Drinking is often followed by drug addiction. The counseled group had only two drug addicts; the uncounseled, three. Drug addiction among high-school youngsters has been over-emphasized. Most high-school children are in the marijuana stage. Seldom do we find boys and girls in the high schools who have reached the stage of heroin.

There were two cases of sex perversion in the counseled group, none in the uncounseled. Both inverters were boys, sixteen and seventeen years of age respectively. Therapy with them was long and tedious.

The practice of masturbation was prevalent both in the counseled and in the uncounseled group; there were 22 cases in the first and 25 in the second. Here, therapy with the girls was more difficult than with the boys. This was due to the fact that guilt feeling was more pronounced in the girls.

Suicidal tendency was present in only one case in the study—a girl, seventeen years of age. She was in the counseled group. She was a bright girl, I.Q. 118, and the possessor of many valuable talents. Her difficulty was unrequited love. The boy in question was eighteen years of age, and, to quote the girl, "no good, but I just can't give him up." She attempted suicide twice, but was unsuccessful both times. The fact that she was rejected made her deprecate her personal worth. She said, "I wanted to die, and I knew he'd be sorry." She came regularly for counseling and therapy for several months. Before the end of the school year she married another boy, and is now making a fair adjustment. She may develop other problems, but the suicidal tendency has disappeared.

Many students develop frustrations over their dullness, especially when they are in unsympathetic homes. One sixteen-year-old girl, with an I.Q. of 92, said, "I'm just dumb—that's all—and I hate it." An over-age boy, with an I.Q. of 89, said, "I study every night, and I think I know the work,

but when the teacher asks me, I just feel dumb and forget everything." Eighteen of the counseled group and 27 of the uncounseled group showed frustrations in this category.

Illness is a major cause of failures in school and failures develop frustrations. Thirty-eight of the counseled and 29 of the uncounseled had frustrations due to illness. The counseled group not only were given medical attention, but therapy as well. The uncounseled received medical attention only.

In their frustrations, some students use such escapes as burglary and truancy. They do not need the things they take; they are seeking attention in spectacular ways. One sixteen-year-old boy, with an I.Q. of 108, said, "Stealing is O.K. if you can get away with it." He cited stealing by political and religious leaders, and emphasized payroll padding and dishonesty in local and national life. Our acceptance of dishonesty at the local and national levels is building a temple of frustration in the minds of our children.

Truancy is a big problem in the city schools. It frequently arises from frustration. A girl in her frustration begins to play truant, and from that may easily drift into shop-lifting and sex delinquency. A boy who develops the habit of truancy may be led into drinking, stealing, and sex without difficulty. Truancy becomes a fixation problem. Twenty-two of the counseled group and 31 of the uncounseled showed this truancy fixation.

What about emotional outbursts? These are prevalent among high-school youngsters. There were four cases of this trait in the counseled group and six in the uncounseled. Such students use crying to get their wants fulfilled. They develop emotional outbursts in their frustrations over failures, disappointments, and even love affairs. This weakness is a demonstration of their immaturity. Many teachers feel helpless when faced with this type of frustration. Such students need counseling. The service of a trained psychologist is needed to help them develop maturity in their behavior.

The types of behavior problem observed in both groups were destructive behavior, some sibling rivalry, a great deal of criminal fixation, drugs, truancy, and stealing.

When the experiment was over, there was a decided diminu-

tion of all problems in the counseled group, except stealing. The types of stealing are more related to other psychosocial patterns, such as those of the family, community attitudes, social pressures, and general acceptance in local and national life.

What about the uncounseled? At the end of the experiment many of them expressed a resigned attitude. A loss of motivation was prevalent. A feeling of helplessness and hopelessness was expressed. Frustration successfully dominated their behavior.

On the surface this type of experiment may appear cold and unfeeling in its neglect of the needs of the uncounseled, but it simply depicts the life of the uncounseled in their frustrations. Psychotherapy and counseling by trained psychologists may save other children from the predicament of the uncounseled.

MENTAL DISEASE AMONG NEGROES IN NEW YORK STATE, 1939-1941

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IN states in which facilities for the treatment of mental disease are sufficiently numerous, it has been shown that rates of first admissions to hospitals for mental disease are higher among Negroes than among the white population. Thus, in New York State, during the three fiscal years ended June 30, 1931, there were 1,841 Negro first admissions to all hospitals for mental disease in New York State, giving an average annual rate of 150.6 per 100,000 of the general Negro population. The white population had a corresponding rate of 87.7 per 100,000 population.¹ The Negro population, therefore, had a higher rate in the ratio of 1.7 to 1. When both rates were adjusted with respect to the varying factor of age, the Negro rate was in excess in the still higher ratio of 2.0 to 1.

Between 1920 and 1930, there was a great growth in the Negro population of New York State, resulting primarily from the migratory movement that followed the first World War. During this decade, the Negro population of New York State increased by 214,331, or 108.0 per cent. During the same decade, the white population increased by only 19.4 per cent.

Migration continued between 1930 and 1940, primarily as a consequence of the economic depression. The Negro population of New York State increased from 412,814 to 571,221, or by 38.4 per cent. This is only a third of the rate of increase during the preceding decade, but it is six times as great as the corresponding rate of increase (6.0 per cent) among the white population.

In view of the increase in population, and because of the relation of migration to the prevalence of mental disease, it

¹ The data for white first admissions during 1929-1931 have been revised throughout this study so as to include voluntary admissions to the private mental hospitals. For administrative reasons, these had formerly been omitted from the official statistics.

is of importance to continue the studies of mental disease among Negroes. The following analysis is based upon the first admissions to all hospitals for mental disease, public and private, in New York State during the three fiscal years that ended June 30, 1941.

During this period there were 3,908 Negro first admissions, and 42,563 white first admissions. Table 1 shows their distribution among the three groups of mental hospitals in New York State.

TABLE 1. FIRST ADMISSIONS TO THE SEVERAL CLASSES OF HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939 TO 1941, INCLUSIVE

	Number		Per cent	
	Negro	White	Negro	White
Civil state hospitals.....	3,685	35,668	94.3	83.8
Hospitals for criminal insane.....	172	508	4.4	1.2
Licensed hospitals	51	6,387	1.3	15.0
Total	3,908	42,563	100.0	100.0

There was a relative excess of first admissions among Negroes to the state hospitals, both civil and criminal, as compared with the white first admissions, and a corresponding deficiency among Negroes of admissions to the licensed hospitals. The latter included two federal hospitals administered by the U. S. Veterans Administration and a hospital administered by the United States Public Health Service. Almost all of the Negroes admitted to licensed hospitals were received by these three federal hospitals. Therefore, practically all Negroes with mental disease in New York State were admitted to public hospitals, either state or federal, whereas a substantial proportion of the white first admissions were treated in private hospitals. The difference was due to the inferior economic status of the Negroes.

Table 2 classifies the 3,908 Negro first admissions according to mental disorders. The largest category was dementia praecox, which included 1,141 cases, or 29.2 per cent of the total. The second largest category—psychoses with cerebral arteriosclerosis—included 610 cases, or 15.6 per cent. General paresis followed closely with 577 cases, or 14.8 per cent. The alcoholic psychoses included 441 cases, or 11.3 per cent.

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TABLE 2. NEGRO FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939-1941

Mental disorders	Number			Per cent			Average annual rate per 100,000 Negro population		
	Males Females Total			Males Females Total			Males Females Total		
General paresis	425	152	577	20.0	8.5	14.8	54.5	16.4	33.9
With other syphills of central nervous system	102	68	170	4.8	3.8	4.4	13.1	7.4	10.0
With epidemic encephalitis	5	3	8	0.2	0.2	0.2	0.6	0.3	0.4
With other infectious diseases	9	19	28	0.4	1.1	0.7	1.2	2.1	1.7
Alcoholic	331	110	441	15.6	6.2	11.3	42.5	11.9	25.9
Due to drugs or other exogenous poisons	3	...	3	0.2	...	0.1	0.4	...	0.2
Traumatic	36	12	48	1.7	0.7	1.2	4.6	1.3	2.8
With cerebral arteriosclerosis	278	332	610	13.1	18.6	15.6	35.7	36.0	35.8
With other disturbances of circulation	18	30	48	0.9	1.7	1.2	2.3	3.3	2.8
With convulsive disorders	39	23	62	1.8	1.3	1.6	5.0	2.5	3.7
Senile	75	113	188	3.5	6.3	4.8	9.6	12.3	11.0
Involuntional	9	53	62	0.4	3.0	1.6	1.2	5.7	3.6
Due to other metabolic, etc., diseases	4	22	26	0.2	1.2	0.7	0.5	2.4	1.5
Due to new growth	5	11	16	0.2	0.6	0.4	0.6	1.2	0.9
With organic changes of nervous system	8	4	12	0.4	0.2	0.3	1.0	0.4	0.7
Manic-depressive	40	87	127	1.9	4.9	3.2	5.1	9.4	7.5
Dementia praecox	526	615	1,141	24.7	34.5	29.2	67.5	66.7	67.0
Paranoia and paranoid conditions	5	4	9	0.2	0.2	0.2	0.6	0.4	0.5
With psychopathic personality	88	36	124	4.1	2.0	3.2	11.3	3.9	7.3
With mental deficiency	68	47	115	3.2	2.6	2.9	8.7	5.1	6.0
Psychoneuroses	22	15	37	1.0	0.8	0.9	2.8	1.6	2.2
Undiagnosed	12	14	26	0.6	0.8	0.7	1.5	1.5	1.5
Without psychosis	9	1	10	0.4	0.1	0.3	1.2	0.1	0.6
Primary behavior disorders	9	11	20	0.4	0.6	0.5	1.2	1.2	1.2
Total	2,126	1,782	3,908	100.0	100.0	100.0	272.8	193.2	229.6

Table 3 shows the corresponding classification for the 42,563 white first admissions. Here also dementia praecox was the leading category, including 10,113 first admissions, or 23.8 per cent. Psychoses with cerebral arteriosclerosis included 7,729 cases, or 21.9 per cent. The senile psychoses were third in order with 4,549 cases, or 10.7 per cent. The alcoholic psychoses included 2,687 cases, or 6.3 per cent, compared with 11.3 per cent among Negroes. General paresis included 2,240 cases, or 5.3 per cent, compared with 14.8 per cent among Negroes.

The average annual rate of first admissions among Negroes was 229.6 per 100,000 Negro population. Distributed in their relative order, the numerically important groups of mental disorders showed the following average annual rates: dementia praecox, 67.0; psychoses with cerebral arteriosclerosis, 35.8; general paresis, 33.9; alcoholic psychoses, 25.9. The rate for the senile psychoses was only 11.0.

The rate for the white population was 110.3 per 100,000 white population, compared with 229.6 for Negroes. The rates among whites for the major groups of mental disorders were correspondingly low. Dementia praecox was the leading category, with a rate of 26.2 per 100,000 population, compared with 67.0 for the Negroes. The rate for psychoses with cerebral arteriosclerosis was 20.0 for whites, compared with 35.8 for Negroes. The rate for involutional psychoses among whites, 7.5, was more than twice that of the Negroes.

The outstanding difference was with respect to psychoses of syphilitic origin. The rate of general paresis was only 5.8 among the white population, compared with 33.9 among Negroes. The relative difference was even greater with respect to psychoses with other forms of syphilis of the central nervous system, the rates being 1.0 and 10.0 for whites and Negroes, respectively. Thus, the combined rate for general paresis and other forms of syphilis was only 6.8 for the white population, compared with 43.9 for the Negro population.

The Negroes were also greatly in excess with respect to the alcoholic psychoses, their rate being 25.9, compared with 7.0 for the whites.

Except for several fluctuations that were undoubtedly fortuitous, the rate of first admissions per 100,000 corresponding population grew among Negroes from 4.3 at the youngest

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TABLE 3. WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939-1941

	Number			Per cent			Average annual rate per 100,000 white population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
<i>Mental disorders</i>									
General paresis	1,699	541	2,240	7.7	2.7	5.3	8.8	2.8	5.8
With other syphilis of central nervous system	273	98	371	1.2	0.4	0.9	1.4	0.6	1.0
With epidemic encephalitis	101	61	162	0.5	0.3	0.4	0.6	0.3	0.4
With other infectious diseases	60	87	147	0.3	0.4	0.3	0.3	0.4	0.4
Alcoholic	2,252	435	2,687	10.2	2.1	6.3	11.7	2.2	7.0
Due to drugs or other exogenous poisons	77	76	153	0.3	0.4	0.4	0.4	0.4	0.4
Traumatic	272	53	325	1.2	0.3	0.8	1.4	0.3	0.8
With cerebral arteriosclerosis	4,206	3,523	7,729	19.0	17.3	18.2	21.9	18.2	20.0
With other disturbances of circulation	137	176	313	0.6	0.9	0.7	0.7	0.9	0.8
With convulsive disorders	356	262	618	1.6	1.3	1.4	1.9	1.4	1.6
Senile	1,876	2,673	4,549	8.5	13.1	10.7	9.8	13.8	11.8
Involutorial	868	2,039	2,907	3.9	10.0	6.8	4.5	10.5	7.5
Due to other metabolic, etc., diseases	70	128	198	0.3	0.6	0.4	0.4	0.7	0.5
Due to new growth	87	71	158	0.4	0.3	0.4	0.5	0.4	0.4
With organic changes of nervous system	166	134	300	0.7	0.7	0.7	0.9	0.7	0.8
Manic-depressive	1,088	2,297	3,385	4.9	11.3	8.0	5.7	11.9	8.8
Dementia praecox	5,126	4,987	10,113	23.1	24.4	23.8	26.7	25.7	26.2
Paranoia and paranoid conditions	184	231	415	0.8	1.1	1.0	1.0	1.2	1.1
With psychopathic personality	568	221	789	2.6	1.1	1.9	3.0	1.1	2.0
With mental deficiency	492	452	944	2.2	2.2	2.2	2.6	2.3	2.4
Psychonervoses	1,007	1,291	2,298	4.6	6.3	5.4	5.2	6.7	6.0
Undiagnosed	165	142	307	0.7	0.7	0.7	0.9	0.7	0.8
Without psychosis	108	356	1,218	3.9	1.7	2.9	4.4	1.8	3.2
Primary behavior disorders	163	74	237	0.7	0.4	0.6	0.8	0.4	0.6
Total	22,155	20,408	42,563	100.0	100.0	100.0	115.4	105.3	110.3

ages to 1,671.1 for those aged 75 or over, as shown in Table 4. Among males, the rates rose from 5.1 to 1,644.6. The corresponding range among the females was from 3.4 to 1,685.9. Except for a slight excess at ages 75 or over, the rates among Negro males were significantly in excess of those for females.

The corresponding data for the white population are shown in Table 5. The rates are significantly lower than those for Negroes at corresponding ages, but the rising trends with age are similar. It is thus evident that the rates for Negroes are higher than those for whites. However, the true order of the difference is concealed by the contrast in the ages of the two populations. Thus, the median age for the Negro first admissions was 40.0 years, compared with 47.9 years for the whites. Half of the Negro first admissions were under 40 years of age, compared with only a third of the whites. This is a reflection of the differences in the two general populations. The Negro population had a median age of 30.3 years in 1940, compared with 32.0 years for the whites. Furthermore, the white population was weighted toward the older ages, the net result being that the total rate for the white population was increased in comparison with that of the Negroes.

The rates for Negroes and whites are, therefore, compared in corresponding age groups in Table 6. The excess of the rates for Negroes is clearly evident. Among those aged less than 10 years, the Negro rate was in excess by 59 per cent. But in all other age groups the Negro rates were in excess by amounts varying from a minimum of 100 per cent to a maximum of 238 per cent. However, the relative excess was greater for Negro males than for Negro females.

Table 7 compares the rates of first admission among Negroes in 1940 with those in 1930. There were large and significant increases in every age group during the decade. In general, the rates for Negro females increased more rapidly than the rates for males in the older age groups.

The preceding differences may be summarized and placed on a comparable basis by the use of standardized rates of first admission. The rates for Negroes in 1940 will be compared with those for Negroes in 1930. Similar comparisons will be made for the white population. Finally, the Negro rates will be compared with the corresponding rates for whites. The population used as standard was that of the state of New

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TABLE 4. NEGRO FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO AGE

Age (years)	Number		Per cent		Males	Females	Total	Males	Females	Total	Males	Females	Total	
	Males	Females	Males	Females										
Under 10	6	4	10	0.3	0.2	0.3	0.3	5.1	3.4	4.3	5.1	3.4	4.3	4.3
10-14	22	14	36	1.0	0.8	0.9	0.9	33.6	20.2	26.7	33.6	20.2	26.7	26.7
15-19	106	101	207	5.0	5.7	5.3	5.3	173.8	141.8	156.6	173.8	141.8	156.6	156.6
20-24	176	143	319	8.3	8.0	8.2	8.2	298.3	151.9	208.3	298.3	151.9	208.3	208.3
25-29	219	209	428	10.3	11.7	11.0	11.0	291.2	188.4	230.0	291.2	188.4	230.0	230.0
30-34	269	219	486	12.7	12.3	12.4	12.4	331.0	209.5	262.7	331.0	209.5	262.7	262.7
35-39	254	214	468	11.9	12.0	12.0	12.0	291.5	207.4	245.9	291.5	207.4	245.9	245.9
40-44	233	157	390	11.0	8.8	10.0	10.0	308.2	202.0	254.4	308.2	202.0	254.4	254.4
45-49	218	150	368	10.3	8.4	9.4	9.4	389.5	263.2	325.8	389.5	263.2	325.8	325.8
50-54	180	103	283	8.4	5.8	7.2	7.2	460.1	250.3	352.5	460.1	250.3	352.5	352.5
55-59	117	103	220	5.5	5.8	5.6	5.6	454.9	372.1	412.0	454.9	372.1	412.0	412.0
60-64	99	88	187	4.7	4.9	4.8	4.8	588.5	477.6	530.5	588.5	477.6	530.5	530.5
65-69	96	97	193	4.5	5.4	4.9	4.9	883.7	677.8	766.7	883.7	677.8	766.7	766.7
70-74	64	57	121	3.0	3.2	3.1	3.1	1,208.0	749.2	987.5	1,208.0	749.2	987.5	987.5
75 or over	67	123	190	3.2	6.9	4.9	4.9	1,634.6	1,685.9	1,671.2	1,634.6	1,685.9	1,671.2	1,671.2
Total	2,126	1,782	3,908	100.0	100.0	100.0	100.0	272.8	193.2	229.6	272.8	193.2	229.6	229.6

TABLE 5. WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939-1941, CLASSIFIED ACCORDING TO AGE

Age (years)	Number			Per cent			Average annual rate per 100,000 White population		
	Males		Total	Males		Females	Males		Females
	Males	Females	Total	Males	Total	Total	Males	Total	Total
Under 10	99	34	133	0.4	0.2	0.3	3.9	1.4	2.7
10-14	149	87	236	0.7	0.4	0.6	9.8	5.9	7.9
15-19	905	746	1,651	4.1	3.7	3.9	55.8	46.4	51.2
20-24	1,538	1,289	2,827	6.9	6.3	6.6	96.7	76.6	88.4
25-29	1,623	1,692	3,315	7.3	8.3	7.8	102.4	97.6	99.9
30-34	1,816	1,746	3,562	8.2	8.6	8.4	114.2	104.5	109.2
35-39	1,945	1,818	3,763	8.8	8.9	8.8	128.5	115.4	119.4
40-44	2,004	1,686	3,690	9.0	8.3	8.7	131.1	111.7	121.4
45-49	1,924	1,746	3,670	8.7	8.6	8.6	134.3	127.3	130.9
50-54	1,973	1,674	3,647	8.9	8.2	8.6	154.9	141.7	148.5
55-59	1,599	1,326	2,925	7.2	6.4	6.9	164.5	142.4	153.7
60-64	1,539	1,336	2,875	6.9	6.5	6.7	207.1	172.4	189.4
65-69	1,491	1,396	2,887	6.7	6.8	6.8	269.9	229.6	248.8
70-74	1,319	1,311	2,630	6.0	6.4	6.2	361.0	310.9	334.2
75 or over	2,231	2,521	4,752	10.1	12.4	11.2	685.7	584.4	620.0
Total	22,155		42,563	100.0	100.0	100.0	115.4	105.3	110.3

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TABLE 6. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS AMONG NEGROES AND WHITES, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION. FISCAL YEARS 1930-1941

Age (years)	Average annual rate among Negroes (a)		Average annual rate among whites (b)		Ratio of (a) to (b)	
	Males	Females	Males	Females	Males	Females
Under 10	5.1	8.4	4.8	8.9	2.7	1.31
0-14	33.6	20.2	26.7	9.8	5.9	3.43
5-19	173.8	141.8	156.6	65.8	46.4	51.2
0-24	298.3	161.9	208.3	96.7	76.6	86.4
5-29	291.2	188.4	230.0	102.4	97.6	99.9
0-34	331.0	209.5	262.7	114.2	104.5	109.2
5-39	291.5	207.4	245.9	123.5	115.4	119.4
0-44	308.2	202.0	254.4	131.1	111.7	121.4
5-49	389.5	263.2	325.8	134.3	127.3	130.9
0-54	460.1	250.3	352.5	154.9	141.7	148.5
5-59	454.9	372.1	412.0	164.5	142.4	153.7
0-64	588.5	477.6	530.5	207.1	172.4	189.4
5-69	883.7	677.8	766.7	269.9	229.6	248.8
0-74	1,208.0	749.2	937.5	361.0	310.9	334.2
5 or over	1,644.6	1,685.9	1,671.1	665.7	584.4	620.0
Total	272.8	193.2	229.6	115.4	105.3	110.3

TABLE 7. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS AMONG NEGROES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS 1939-1941 AND 1929-1931

Age (years)	Average annual rate 1939-1941 (a)			Average annual rate, 1929-1931 (b)			Ratio of (a) to (b)		
	Males		Total	Males		Total	Males		Total
	Males	Females		Males	Females		Males	Females	
Under 15	15.4	9.6	12.4	8.7	5.9	7.3	1.77	1.63	1.70
15-19	173.8	141.8	156.6	118.2	113.4	115.5	1.47	1.25	1.36
20-24	298.3	151.9	208.3	171.7	115.2	140.0	1.74	1.32	1.49
25-29	291.2	188.4	230.0	165.3	124.9	144.1	1.76	1.51	1.60
30-34	331.0	209.5	262.7	160.9	176.1	167.0	2.06	1.21	1.57
35-39	281.5	207.4	245.9	209.0	189.4	195.9	1.39	1.14	1.26
40-44	308.2	209.0	254.4	238.6	204.4	221.8	1.29	0.99	1.15
45-49	389.5	263.2	325.8	293.3	207.4	251.1	1.33	1.27	1.30
50-54	460.1	250.3	352.5	322.7	199.8	262.6	1.43	1.25	1.34
55-59	454.9	372.1	412.0	365.9	265.0	315.5	1.24	1.40	1.31
60-64	588.5	477.6	530.5	481.9	275.0	372.6	1.22	1.74	1.42
65-69	883.7	677.8	766.7	533.3	393.4	451.3	1.66	1.72	1.70
70-74	1,208.0	749.2	937.5	928.8	400.6	617.4	1.30	1.87	1.52
75 or over	1,644.6	1,685.9	1,671.1	543.1	877.9	749.1	3.03	1.92	2.23
Total	272.8	193.2	220.6	168.1	134.2	150.6	1.62	1.44	1.52

York on April 1, 1940, aged 15 years or over, the population being taken in intervals of five years.

The Negro population had a standardized rate of first admission in 1940 of 359.1 per 100,000 population, compared with 243.3 in 1930, the former being in excess by 48 per cent. (See Table 8.) Both sexes showed increased rates during the decade, the male rate increasing by 53 per cent, the female rate by 40 per cent.

Among the white population the standardized rate increased from 120.5 per 100,000 population in 1930 to 136.8 in 1940, an increase of 14 per cent. This was less than a third of the corresponding increase among Negroes. White males and females both showed increased rates of first admission in 1940. The rate of increase was much less than that of the Negroes, however. Furthermore, though the male rate among Negroes increased more rapidly than that of the females, the reverse was true among the white population.

We may also note that in 1930 the Negro male rate exceeded that of Negro females by 30 per cent. In 1940 the excess increased to 41 per cent. Among the white population, on the contrary, the male rate exceeded that of the females by 30 per cent in 1930, but by only 8 per cent in 1940.

The final summary shows that the standardized rate of first admissions for Negroes in 1940 exceeded that of the white population by 163 per cent. In 1930 the corresponding excess had been 102 per cent. Thus, not only did rates of first admission increase among both Negroes and whites during the decade, but the rate of increase was greater for Negroes than for whites.

The excess was particularly marked in the case of Negro males. Their standardized rate exceeded that of the white males by 95 per cent in 1930, but the excess amounted to 182 per cent in 1940. Among females the Negro rate was in excess during both years, but the excess increased from 96 per cent in 1930 to only 115 per cent in 1940.

We shall next examine differences in rates of first admissions for four groups of mental disorders which are of importance either because of their numerical frequency, or because of certain social implications.

General Paresis.—There were 577 Negro first admissions with general paresis during the three years ended June 30,

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TABLE 8. AVERAGE ANNUAL STANDARDIZED RATES OF FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE AMONG NEGROES AND WHITES, FISCAL YEARS 1939-1941 AND 1929-1931

	Negro			White			Ratio of Negro to white		
	1940	1930	Ratio	1940	1930	Ratio	1940	1930	
Males	405.3 ± 9.6	265.0 ± 8.8	1.53 to 1	143.8 ± 1.1	135.6 ± 1.2	1.06 to 1	2.82 to 1	1.95 to 1	
Females	285.9 ± 7.3	204.3 ± 7.4	1.40 to 1	133.0 ± 1.1	104.2 ± 1.0	1.28 to 1	2.15 to 1	1.96 to 1	
Total	359.1 ± 6.1	243.3 ± 5.8	1.48 to 1	136.8 ± 0.8	120.5 ± 0.8	1.14 to 1	2.63 to 1	2.02 to 1	

Age (years)	Average annual rate 1939-1941 (a)			Average annual rate 1929-1931 (b)			Ratio of (a) to (b)		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15	1.1	1.1	1.1	...	...	...	...	...	...
15-19	4.9	2.8	3.8	2.8	2.2	2.5	1.8	1.3	1.5
20-24	3.4	4.3	3.9	8.0	2.5	4.9	0.4	1.7	0.8
25-29	27.9	13.5	19.7	14.5	9.8	12.0	1.9	1.4	1.6
30-34	78.7	20.1	45.7	33.8	13.6	23.8	2.3	1.4	1.9
35-39	91.8	23.3	54.7	57.4	30.2	43.9	1.6	0.8	1.2
40-44	78.0	33.4	55.4	79.5	28.3	54.4	1.0	1.2	1.0
45-49	134.0	35.1	84.1	106.9	39.8	73.9	1.3	0.9	1.1
50-54	143.1	26.7	83.4	118.9	26.6	73.8	1.2	1.0	1.1
55-59	101.1	36.3	67.4	147.9	39.0	93.5	0.7	0.9	0.7
60-64	95.1	65.1	79.4	66.9	23.9	44.2	1.4	2.7	1.8
65-69	119.7	21.0	63.6	48.5	68.4	60.2	2.4	0.3	1.1
70 or over.....	85.4	13.4	41.2	89.5	29.5	53.3	1.0	0.4	0.8
Total	54.5	16.4	33.9	36.9	13.9	25.0	1.4	1.2	1.4

1941, or an average annual rate of 33.9 per 100,000 population. (See Table 2.) In general, the rates rose to a maximum in the fifth decade of life, and declined at the older ages. Despite the decline, however, the rates in the older age groups exceeded those at the younger ages (*i.e.*, under 45 years). The maximum rate among females was reached at a later age than among males. At corresponding ages, however, the male rates were greatly in excess.

The average annual rates during 1939-1941 are compared with those of the previous decade in Table 9. The male rate increased during the decade from 36.9 to 54.5; the latter being in excess by almost 50 per cent. The rates for females increased from 13.9 to 16.4, an increase of 18 per cent. The rates for both sexes increased from 25.0 to 33.9, an increase of 36 per cent. Among the males there were increased rates at almost every age. In the case of the females, however, the increases were concentrated among those under 35 years of age.

The rates for Negroes are compared with those for the white population in Table 10. It is apparent that the former are in great excess in all corresponding age groups. The differences are summarized in Table 11, which provides standardized rates for the two populations for the decades 1939-1941, and 1929-1931. The standard population in each case was that of the state of New York, as shown by the census of April 1, 1940, beginning at age 15, the population being divided into intervals of 5 years.

On this basis, we find that the Negro males had a rate of 73.2 per 100,000 population in 1940, compared with 22.5 among Negro females. The male rate increased from 58.7 in 1930 to 73.2 in 1940, whereas the female rate was practically constant. For both sexes combined, the standardized rate increased from 40.9 to 47.3.

These rates are significantly in excess of those for the white population, both in 1940 and in 1930. In the latter year, the rate for Negroes exceeded that for the white population by 290 per cent. In 1940, however, the Negro rate was in excess by 566 per cent. This resulted from the significant fact that, whereas the rate for general paresis decreased among the white population from 10.5 to 7.1 per 100,000 population between 1930 and 1940, the corresponding rate among Negroes

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TABLE 10. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH GENERAL PARESIS AMONG NEGROES AND WHITES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS, 1939-1941

Age (years)	Average annual rate among Negroes (a)			Average annual rate among whites (b)			Ratio of (a) to (b)		
	Males		Total	Males		Females	Total	Males	Females
	Males	Females		Males					
Under 15	1.1	1.1	1.1	0.1	0.1	0.1	0.1	11.0	11.0
15-19	4.9	2.8	3.8	0.4	0.8	0.6	0.6	12.3	3.5
20-24	3.4	4.3	3.9	0.4	0.5	0.4	0.4	8.5	8.6
25-29	27.9	13.5	19.7	2.1	1.7	1.9	1.7	13.3	7.9
30-34	78.7	20.1	45.7	8.6	8.7	6.1	6.1	9.2	5.4
35-39	91.8	23.3	54.7	14.7	5.6	10.2	6.2	4.2	4.2
40-44	78.0	33.4	55.4	20.4	6.6	13.1	3.8	6.0	4.2
45-49	134.0	35.1	84.1	20.2	3.3	12.9	6.6	10.6	6.5
50-54	143.1	26.7	83.4	21.4	6.4	13.7	6.7	4.9	6.1
55-59	101.1	36.3	67.4	17.8	4.0	11.5	5.7	9.1	5.9
60-64	95.1	65.1	79.4	14.8	4.3	9.4	6.4	15.1	8.4
65-69	119.7	21.0	63.6	13.2	3.1	7.9	9.1	6.8	8.1
70 or over	85.4	13.4	41.2	6.6	1.9	4.0	12.9	7.1	10.3
Total	54.5	16.4	33.9	8.8	2.8	5.8	6.2	5.9	5.8

TABLE 11. AVERAGE ANNUAL STANDARDIZED RATES OF FIRST ADMISSIONS WITH GENERAL PARESIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE AMONG NEGROES AND WHITES, FISCAL YEARS 1939-1941 AND 1929-1931

Negro	White			Ratio of Negro to white		
	1940	1930	Ratio	1940	1930	Ratio
Males	73.2 ± 4.1	58.7 ± 4.1	1.24 to 1	11.1 ± 0.3	17.3 ± 0.4	0.64 to 1
Females	22.5 ± 2.0	22.4 ± 2.4	1.00 to 1	3.3 ± 0.2	4.0 ± 0.2	0.83 to 1
Total	47.3 ± 2.2	40.9 ± 2.4	1.16 to 1	7.1 ± 0.2	10.5 ± 0.2	0.68 to 1

increased from 40.9 to 47.3. The rate of first admissions with general paresis has fallen steadily in New York State since 1920, yet not only is general paresis more prevalent among Negroes than among whites, but the former have actually shown an increase during the decade 1930-1940.

Alcoholic Psychoses.—There were 441 Negro first admissions with alcoholic psychoses to all hospitals for mental disease in New York State during the three years ended June 30, 1941. (See Table 2.) This represented an average annual rate of 25.9 per 100,000 population. The Negro male and female first admissions with alcoholic psychoses totaled 331 and 110, respectively. The average annual rates were 42.4 and 11.9, respectively, the former being in excess in the ratio of 3.6 to 1. The rates rose from minima at ages under 20 to a maximum of 58.1 at ages 40 to 44, and then declined to 12.4 at ages 70 or over. The maximum rates occurred at an earlier age among females than among males. At each age, however, the male rate was in excess in ratios of 3 to 1 or 4 to 1.

Table 12 compares the average annual rates in 1940 with those of 1930. The total rate increased from 15.1 in 1930 to 25.9 in 1940, an increase of 72 per cent. The rates increased at all ages, the most rapid increases occurring at ages 25 to 34. The rates increased more rapidly among males than among females.

The average annual rates among Negroes in 1940 are compared with those of the whites in Table 13. The Negro rate, 25.9, exceeded that of the whites, 7.0, by 270 per cent. The rates were in the ratio of 29.5 to 1 at ages 20 to 24. Though the Negroes had higher rates at every age, the ratios declined with advancing age. The relative excess was greater for females than for males. Thus, the Negro male rate exceeded that of the whites in the ratio of 3.6 to 1. The Negro female rate was in excess in the ratio of 5.4 to 1.

Summary comparisons on the basis of standardized rates are shown in Table 14. The standard population was that of New York State on April 1, 1940, in five-year intervals, beginning with age 20.

The Negro rate increased from 22.4 in 1930 to 36.8 in 1940. The male rate increased from 34.2 to 59.1, an increase of 73 per cent. The female rate increased from 11.3 to 15.4, an increase of only 36 per cent.

TABLE 12. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES AMONG NEGROES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS 1939-1941 AND 1929-1931

Age (years)	Average annual rate 1939-1941 (a)			Average annual rate 1929-1931 (b)			Ratio of (a) to (b)		
	Males		Total	Males		Total	Males	Females	Total
	Males	Females		Males	Females				
15-19	1.6	...	0.8	...	...	...	...	...	...
20-24	18.6	7.4	11.8	8.0	6.0	6.3	2.3	1.4	1.9
25-29	43.9	16.3	27.3	18.1	5.4	11.4	2.4	2.8	2.4
30-34	72.6	22.0	44.1	29.8	12.3	21.0	2.4	1.8	2.1
35-39	59.7	23.3	39.9	35.3	22.6	29.1	1.7	1.0	1.4
40-44	89.9	20.6	58.1	43.9	17.4	30.9	2.0	1.2	1.9
45-49	91.1	19.3	54.9	74.0	11.4	43.2	1.2	1.7	1.3
50-54	61.3	14.6	37.4	34.0	17.8	26.0	1.8	0.8	1.4
55-59	58.3	14.4	35.6	31.1	15.6	23.4	1.9	0.9	1.5
60-64	53.5	5.4	28.4	30.7	18.7	1.3	...	...	1.5
65-69	46.0	7.0	23.8	48.0	...	19.8	1.0	...	1.2
70 or over	32.0	...	12.4	22.2	...	8.8	1.4	...	1.4
Total	42.4	11.9	25.9	22.6	8.1	15.1	1.9	1.4	1.7

TABLE 13. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES AMONG NEGROES AND WHITES, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS 1939-1941

Age (years)	Average annual rate among Negroes (a)			Average annual rate among whites (b)			Ratio of (a) to (b)
	Males		Total	Males		Total	
	Males	Females	Total	Males	Females	Total	
15-19	1.6	...	0.8	...	...	...	...
20-24	18.6	7.4	11.8	0.8	0.1	0.4	23.3
25-29	43.9	15.3	27.3	4.9	1.4	3.1	74.0
30-34	72.6	22.0	44.1	12.6	3.2	7.8	9.0
35-39	59.7	23.3	39.9	22.1	3.7	12.9	5.8
40-44	89.9	20.6	58.1	24.3	4.2	14.3	2.7
45-49	91.1	19.3	54.9	26.9	4.4	15.8	3.7
50-54	61.3	14.6	37.4	27.9	5.6	17.1	4.4
55-59	58.3	14.4	35.6	23.7	4.8	14.0	2.2
60-64	53.5	5.4	28.4	21.1	4.9	12.8	2.6
65-69	46.0	7.0	23.8	16.8	2.3	9.2	2.5
70 or over	32.0	...	12.4	4.4	1.8	2.7	1.1
Total	42.4	11.9	25.9	11.7	2.2	7.0	3.0
							2.7
							7.3
							...
							4.6
							3.7

TABLE 14. AVERAGE ANNUAL STANDARDIZED RATES OF FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE AMONG NEGROES AND WHITES, FISCAL YEARS 1939-1941 AND 1929-1931

Negro	White			Ratio of Negro to white
	1940		1930	
	1940	1930	Ratio	
Males	59.1 ± 3.9	34.2 ± 3.3	1.73 to 1	16.7 ± 0.4
Females	15.4 ± 1.8	11.3 ± 1.8	1.36 to 1	3.2 ± 0.2
Total	36.8 ± 2.0	22.4 ± 1.9	1.64 to 1	9.8 ± 0.2

The rate of the white population increased during the decade from 7.7 to 9.8, an increase of 27 per cent. Both sexes showed increases during the decade, but unlike the Negroes, the increase among white females exceeded that of white males.

The Negro rate exceeded that of the whites in the ratio of 2.91 to 1 in 1930. In 1940, the Negro rate had grown more rapidly, so that the rates were in the ratio of 3.76 to 1. This was due almost entirely to the more rapid growth of the rate among Negro males. In 1930 the Negro male rate exceeded that of the whites in the ratio of 2.55 to 1. In 1940 the rates were in the ratio of 3.54 to 1. The rates of the Negro females were in almost the same relative excess over those for white females during the two periods.

Psychoses with Cerebral Arteriosclerosis.—There were 610 Negro first admissions with psychoses with cerebral arteriosclerosis during the three years ended June 30, 1951, of whom 278 were males and 332 females. (See Table 2.) The crude rate per 100,000 population was 35.8. Males and females had crude rates of 35.7 and 36.0, respectively. The rates show no significant difference with respect to sex, though males generally have a higher rate than females in this respect.

The average annual rate rose steadily from 2.1 per 100,000 population at ages 35 to 39 to a maximum of 782.8 at 75 or over. Table 15 compares the average annual rates during 1939-1941 with those for the preceding decade. There was a striking increase during the decade. The male rate advanced from 13.0 to 35.7, an increase in the ratio of 2.7 to 1. The female rate advanced from 12.8 to 36.0, the latter being in excess in the ratio of 2.8 to 1. In general, each age group showed a significant increase during the decade.

Table 16 compares the rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes and whites in 1940. It is evident that the rates for Negroes exceeded those of the white population in all age groups. The excess was greatest at ages 40 to 49, the ratios of the two sets of rates decreasing steadily with advancing age. It is significant that the rates for Negro females exceeded those of white females at each age in ratios exceeding those of the males. The rates are summarized in Table 17 for 1940 and 1930, sex and age proportions being held constant through standardization. The standard population was that of New

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TABLE 15. AVERAGE ANNUAL RATE OF FIRST ADMISSIONS WITH PSYCHOSIS WITH CEREBRAL ARTERIOSCLEROSIS AMONG NEGROES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS, 1939-1941 AND 1929-1931

Age (years)	Average annual rate 1929-1941 (a)			Average annual rate, 1929-1931 (b)			Ratio of (a) to (b)		
	Males		Total	Males		Females	Total	Males	Females
	Males	Females		Males				Total	Total
35-39 .....	...	3.9	2.1	1.5		3.0	2.2	...	1.3
40-44	6.6	14.2	10.4	4.2		13.0	8.5	1.6	1.1
45-49	19.7	35.1	27.4	11.0		25.6	18.1	1.8	1.4
50-54	112.5	87.5	99.7	46.7		40.0	43.4	2.4	2.2
55-59	194.4	183.2	189.1	101.2		101.3	101.3	1.9	1.8
60-64	315.1	271.4	292.2	267.7		155.4	208.4	1.2	1.7
65-69	469.4	489.2	480.7	193.9		188.1	190.5	2.4	2.6
70-74	622.9	420.6	503.6	574.6		215.7	363.2	1.1	1.9
75 or over	760.9	795.0	782.8	226.0		311.5	278.7	3.4	2.6
Total	35.7	36.0	35.8	13.0		12.8	12.9	2.7	2.8

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TABLE 16. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS AMONG NEGROES AND WHITES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS 1939-1941

Age (years)	Average annual rate among Negroes (a)			Average annual rate among whites (b)			Ratio of (a) to (b)		
	Males		Total	Males		Females	Total	Males	Females
	Males	Females		Males					
35-39	...	3.9	2.1	...	...	0.4	0.2	...	9.8
40-44	6.6	14.2	10.4	0.9	0.6	0.8	0.8	7.3	23.7
45-49	19.7	35.1	27.4	3.0	4.1	3.5	3.5	6.6	8.6
50-54	112.5	87.5	99.7	20.1	14.7	17.5	17.5	5.6	6.0
55-59	194.4	183.2	189.1	49.4	40.3	45.0	45.0	3.9	4.5
60-64	315.1	271.4	292.2	103.5	85.2	94.1	94.1	3.0	3.2
65-69	469.4	489.2	480.7	168.0	125.5	145.7	145.7	2.8	3.9
70-74	622.9	420.6	503.6	211.6	154.9	181.7	181.7	2.9	2.7
75 or over	760.9	795.0	788.8	281.1	190.8	230.3	230.3	2.7	4.2
Total	35.7	36.0	35.8	22.0	18.2	20.0	20.0	1.6	2.0
								1.8	

TABLE 17. AVERAGE ANNUAL STANDARDIZED RATES OF FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE AMONG NEGROES AND WHITES, FISCAL YEARS 1939-1941 AND 1929-1931

Negro	White			Ratio of Negro to white		
	1940	1930	Ratio	1940	1930	Ratio
Males	233.8 ± 14.2	134.1 ± 14.2	1.74 to 1	73.2 ± 1.3	53.0 ± 1.3	1.38 to 1
Females	215.3 ± 13.0	103.1 ± 12.2	2.09 to 1	55.4 ± 2.4	36.1 ± 1.1	1.53 to 1
Total	234.1 ± 9.8	122.3 ± 9.5	1.91 to 1	67.0 ± 0.9	45.9 ± 0.8	1.46 to 1
						3.49 to 1
						2.66 to 1

York State as shown by the census of April 1, 1940. The standard population was taken in intervals of five years, beginning with age 45.

The standardized rate grew among Negroes from 122.3 per 100,000 population in 1930 to 234.1 in 1940, an increase of 91 per cent. Both sexes showed increases, the rate of growth being greatest for the Negro females. In both years, the male rate exceeded that of the females, though the differences are not significant with respect to the probable errors. However, the direction of the difference agrees with past experience.

The standardized rates for the white population also increased between 1930 and 1940, though they were at a lower level than those for the Negro population, and the rates of increase were less. Because of the latter, the Negro rate, which was in excess in 1930 by 166 per cent, exceeded that of the whites in 1940 by 249 per cent.

In general, the Negroes had higher rates of first admissions with psychoses with cerebral arteriosclerosis than the whites, and they also showed a more rapid rate of increase during the decade 1930-1940.

Dementia Praecox.—There were 1,141 Negro first admissions with dementia praecox during the three years ended June 30, 1941, of whom 526 were males and 615 females. (See Table 2.) The average annual rate per 100,000 population was 67.0. Males and females had rates of 67.5 and 66.7, respectively. The rate rose rapidly from 5.2 per 100,000 population at ages 10 to 14 to a maximum of 128.0 at ages 20 to 24. The rates decreased steadily at subsequent ages. The trends were the same for each sex, but the maximum rate occurred at an earlier age among males. It is also evident (see Table 18) that the male rates exceeded those of the females below age 30, but were lower after age 30.

Negroes had a rate of first admission with dementia praecox of 44.4 per 100,000 population in 1930, compared with 67.0 in 1940. The latter was in excess by 50 per cent. Males and females both showed significant increases between 1930 and 1940. In general, the rates increased more rapidly among females than among males. The rates of increase were especially high for each sex between ages 15 and 29. The rate of increase decreased with advancing age.

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TABLE 18. AVERAGE ANNUAL RATE OF FIRST ADMISSIONS WITH DEMENTIA PRATOX AMONG NEGROES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS, 1939-1941 AND 1929-1931

Age (years)	Average annual rate 1939-1941 (a)			Average annual rate 1929-1931 (b)			Ratio of (a) to (b)		
	Males		Total	Males		Females	Total	Males	Females
	Males	Females		Males					
10-14	7.6	1.4	5.2	6.7	...	...	2.7	1.3	1.9
15-19	95.1	85.4	90.0	47.9	30.5	38.1	1.0	0.8	2.4
20-24	189.8	89.2	128.0	94.7	41.3	64.7	1.0	0.2	2.0
25-29	142.3	105.6	122.3	80.8	53.2	66.3	1.8	2.0	1.8
30-34	112.0	117.7	115.2	59.5	79.1	69.2	1.9	1.4	1.7
35-39	75.7	102.8	90.4	57.4	57.3	57.4	1.3	1.8	1.6
40-44	69.5	63.0	61.7	52.3	67.4	59.7	1.1	0.9	1.0
45-49	37.5	70.2	54.0	30.2	68.2	48.8	1.2	1.0	1.1
50-54	33.2	26.7	29.0	29.7	40.0	34.7	1.1	0.7	0.9
55-59	17.2	61.7	44.9	30.7	46.2	38.4	0.6	1.3	1.2
60-64	...	2.7	11.3	13.2	35.5	25.0	...	0.1	0.4
65-69	2.2	14.0	11.1	...	16.9	9.9	...	0.9	0.1
70 or over	...	...	...	...	...	...	...	...	...
Total	67.5	66.7	67.0	46.9	42.1	44.4	1.4	1.6	1.5

Table 19 shows the average annual rates of Negroes and whites in 1940 at corresponding ages. The crude rate of the Negroes exceeded that of the whites by 156 per cent. The rates of the Negroes were in excess at every age, but the excess was greatest, in general, in the youngest age groups.

Final comparisons may be found in Table 20, which includes standardized rates for Negroes and whites in 1930 and 1940. The standard population was taken as that of New York State on April 1, 1940, proceeding in five-year intervals from age 15.

The standardized rate for Negroes advanced from 49.1 in 1930 to 76.1 in 1940. Both sexes showed significant increases. Though the rates for Negro males and females were almost equal in 1930, the male rate was in excess in 1940, though the difference was not statistically significant.

In both 1930 and 1940, the Negro rates were significantly in excess of those of the white population. The relative excess was greater in 1940, however, the excess increasing from 77 per cent in 1930 to 131 per cent in 1940.

We may conclude that the rate of first admissions with dementia praecox was higher for Negroes than for whites and that the relative excess was greater in 1940 than in 1930.

Mental Disease in New York City.—The preceding comparisons are affected unduly by an important difference in the distribution of the white and Negro populations of New York State. Of the 571,221 Negroes in the state on April 1, 1940, 539,687, or 94.4 per cent, were living in an urban environment, compared with 82.3 per cent of the white population. Furthermore, 80.3 per cent of the Negroes were living in New York City, compared with only 54.2 per cent of the whites. Therefore, in using the state as a unit, we are comparing a population concentrated primarily in New York City with another population, almost half of which is in up-state New York. As it is known that rates of first admissions are higher in New York City than in the remainder of the state, it is necessary to adjust for this factor. Therefore, another comparison is appended showing average annual standardized rates of first admissions for Negroes and whites in New York City during the three years ended June 30, 1941. (See Table 21.) The standard populations are the same as those employed in the preceding sections.

The standardized rate of first admissions (all psychoses)

TABLE 19. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH DEMENTIA PRALOX AMONG NEGROES AND WHITES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 100,000 CORRESPONDING POPULATION, FISCAL YEARS 1939-1941

Age (years)	Average annual rate among Negroes (a)			Average annual rate among whites (b)			Ratio of (a) to (b)		
	Males		Total	Males		Females	Males		Females
	Males	Females							
10-14	7.6	1.4	5.2				1.7	4.8	0.8
15-19	95.1	85.6	90.0	33.1	26.8	30.0	2.9	3.2	3.0
20-24	189.8	89.2	128.0	64.2	44.4	54.1	3.0	2.0	2.4
25-29	142.3	105.5	122.3	61.4	51.7	56.4	2.3	2.0	2.2
30-34	112.0	117.7	115.2	51.7	46.8	49.2	2.2	2.5	2.4
35-39	75.7	102.8	90.4	41.5	48.5	45.0	1.8	2.1	2.0
40-44	59.5	63.0	61.3	29.5	33.8	31.9	2.0	1.9	1.9
45-49	37.5	70.2	54.0	22.1	27.3	24.6	1.7	2.6	2.2
50-54	33.2	26.7	29.9	13.7	18.6	16.0	2.4	1.4	1.9
55-59	17.2	61.7	44.9	10.0	14.1	12.0	1.7	5.6	3.7
60-64 .....	...	21.7	11.3	4.3	7.4	5.9	...	2.9	1.9
65-69	9.2	14.0	11.9	2.4	4.4	3.4	3.8	3.2	3.6
70-74 .....	...	...	...	...	2.1	1.1	...	...	...
75 or over .....	...	...	...	1.2	1.9	1.6	...	...	...
Total	67.5	66.7	67.0	26.7	31.7	31.2	2.1	2.1	2.1

TABLE 20. AVERAGE ANNUAL STANDARDIZED RATES OF FIRST ADMISSIONS WITH DEMENTIA PRÆCOX TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, AMONG NEGROES AND WHITES, FISCAL YEARS 1939-1941 AND 1929-1931

	Negro			White			Ratio of Negro to white		
	1940	1930	Ratio	1940	1930	Ratio	1940	1930	Ratio
Males	78.5 ± 4.2	49.1 ± 3.8	1.60 to 1	33.6 ± 0.6	31.2 ± 0.6	1.08 to 1	2.34 to 1	1.57 to 1	
Females	73.4 ± 3.7	49.4 ± 3.7	1.49 to 1	32.1 ± 0.5	24.5 ± 0.5	1.31 to 1	2.29 to 1	2.02 to 1	
Total	76.1 ± 2.8	49.1 ± 2.6	1.54 to 1	32.0 ± 0.4	27.7 ± 0.4	1.19 to 1	2.31 to 1	1.77 to 1	

TABLE 21. AVERAGE ANNUAL STANDARDIZED RATES OF FIRST ADMISSIONS AMONG NEGROES AND WHITES FROM NEW YORK CITY TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, FISCAL YEARS 1939-1941, INCLUSIVE

	Negro			White			Ratio of rate among Negroes to that of whites		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
All first admissions*	467.3 ± 11.6	292.6 ± 8.1	381.0 ± 6.9	163.4 ± 1.7	143.9 ± 1.5	160.1 ± 1.1	2.77 to 1	2.03 to 1	2.38 to 1
General paresis*	77.4 ± 4.7	22.7 ± 2.3	49.6 ± 2.5	11.9 ± 0.4	3.5 ± 0.2	7.6 ± 0.2	6.50 to 1	6.49 to 1	6.53 to 1
Alcoholic†	67.2 ± 4.7	16.9 ± 2.1	41.6 ± 2.4	20.6 ± 0.6*	4.1 ± 0.3	12.1 ± 0.3	3.26 to 1	4.12 to 1	3.44 to 1
With cerebral arteriosclerosis‡	296.8 ± 18.2	249.5 ± 15.6	284.4 ± 12.2	99.2 ± 2.1	75.2 ± 1.9	91.0 ± 1.4	2.99 to 1	3.32 to 1	3.12 to 1
Dementia praecox*	88.3 ± 5.3	79.4 ± 4.2	83.8 ± 3.3	40.3 ± 0.6	37.6 ± 0.8	39.0 ± 0.8	2.19 to 1	2.11 to 1	2.14 to 1

* Population of New York State April 1, 1940, aged 15 years or over (in intervals of 5 years) taken as standard.

† Population of New York State April 1, 1940, aged 20 years or over (in intervals of 5 years) taken as standard.

‡ Population of New York State April 1, 1940, aged 45 years or over (in intervals of 5 years) taken as standard.

was 381.6 per 100,000 population for Negroes and 160.1 for the white population, the former being in excess in the ratio of 2.38 to 1. Limitation of the rates to New York City increased the rates of Negroes and whites in comparison with the corresponding rates for the entire state, but the relative increase was greater for the white population. Thus, the excess of the Negro rate was reduced from 163 to 138 per cent.

The sex differences were marked. Among Negroes the male rate exceeded that of the females by 60 per cent. Among the white population the male rate was in excess by only 12 per cent. The Negro male rate exceeded that of the whites by 177 per cent. The corresponding excess among females was 103 per cent.

The greatest relative differences occurred in connection with general paresis. The rate for Negroes exceeded that for whites in the ratio of 6.53 to 1, or by 553 per cent. A smaller, but still significant, excess occurred in connection with the alcoholic psychoses. The Negro rate was in excess in the ratio of 3.44 to 1. The rate of the Negro females was in even greater excess, the ratio of the two rates being 4.12 to 1. There was a great excess of psychoses with cerebral arteriosclerosis among Negroes, their rate exceeding that of the whites in the ratio of 3.13 to 1. In the major group of dementia praecox, the rate of the Negroes was in excess in the ratio of 2.14 to 1.

SUMMARY

It is evident that, whether the comparisons are state-wide or limited to New York City, Negroes had significantly higher rates of first admissions to hospitals for mental disease than the white population. Not only were their rates higher, but the rates for Negroes increased during the decade 1930-1940 more rapidly than those for whites.

As in previous investigations, the greatest divergence was found with respect to general paresis. This attests not only to the greater prevalence of advanced states of syphilis among Negroes, but also to the fact that preventive measures have not yet met the problem effectively. Thus, general paresis increased among Negroes in New York State at the very time that this disorder was decreasing steadily among the rest of the population. Syphilis and its sequelæ, therefore, remain a major problem among Negroes.

The alcoholic psychoses are also prevalent to a greater degree among Negroes than among whites, and increased more rapidly among the former during the decade 1930-1940.

The implications are clear. There have been no racial or genetic changes that can explain the general excess of mental disease among Negroes in New York State, nor can such factors explain the marked increase during a period of only ten years. There are, however, social factors, which are surely related to the prevalence of mental disease in New York State. We may point to the fact of migration, which has been shown to be of epidemiological significance in relation to mental disease. Of the native white population of New York State on April 1, 1940, 86.7 per cent were born in New York State. Among Negroes, the corresponding percentage was less than 40. Of the white first admissions, 75 per cent were born in New York, compared with only 10 per cent of the Negroes.

Migration is, therefore, a fundamental aspect of life among Negroes in New York State. Migration is related to the economic status of the Negroes through association with a low occupational level and a low wage level. Both determine the living conditions of the vast majority of Negroes. It is these conditions that affect health, especially in border-line cases, where difficult circumstances often tip the balance.

Social programs directed towards improving the conditions of life, such as greater economic security and better and more adequate housing, may, therefore, be expected to result in better health for Negroes.

BOOK REVIEWS

MAN'S SEARCH FOR HIMSELF. By Rollo May. New York: W. W. Norton and Company, 1953. 281 p.

Here is another instance in which a psychologist, at one time more or less a disciple of Freud, has specialized in problems with which the master did not deal. Chairman of the Joint Council of New York State Psychologists, author of *The Meaning of Anxiety*, teacher in the William Alanson White Institute, Dr. May examines what other grounds than sex trouble or inferiority complex occasion the painful insecurity, loneliness, and emptiness so common to-day, and what can be done to build up inner strength. These feelings of futility, he says, may owe something to the depressing world conditions of our time:

"The widespread drug addiction among high-school students in New York City has been quite accurately related to the fact that great numbers of these adolescents have very little to look forward to except the army and unsettled economic conditions, and are without positive, constructive goals. The human being cannot live in a condition of emptiness for very long: if he is not growing toward something, he does not merely stagnate; the pent-up potentialities turn into morbidity and despair, and eventually into destructive activities. What is the psychological origin of this experience of emptiness?" (p. 24).

The feeling seems to be interwoven with two others—anxiety and loneliness:

"In fear we know what threatens us, we are energized by the situation, our perceptions are sharper, and we take steps to run, or in other appropriate ways to overcome the danger. In anxiety, however, we are threatened without knowing what steps to take to meet the danger. Anxiety is the feeling of being 'caught,' 'overwhelmed'; and instead of becoming sharper, our perceptions generally become blurred or vague. . . . Fear is a threat to one side of the self—if a child is in a fight, he may get hurt, but that hurt would not be a threat to his existence; or the university student may be somewhat scared by a mid-term, but he knows the sky will not fall in if he does not pass it. But as soon as the threat becomes great enough to involve the total self, one then has the experience of anxiety. Anxiety strikes us at the very 'core' of ourselves: it is what we feel when our existence as selves is threatened. . . . Anxiety disorients us, wiping out temporarily our clear knowledge of what and who we are, and blurring our view of reality around us" (pp. 39, 40, 44).

The main concern then, says May, must be to learn how to use these anxieties constructively. Another way of stating this is to say that effort must go into "the venture of becoming aware of ourselves," discovering the sources of inner security which reward such a venture.

The person who condemns himself should be reminded that while this is the easiest way to drown the bitter ache of feeling worthless, and while he may simply be illustrating the truth of Spinoza's remark, "One who despises himself is the nearest to a proud man," nevertheless, a truer self-awareness may reveal the fact that he is still capable of creatively expressing his potentialities for living with himself and with other people.

This is no easy prescription. It calls for struggle, for overcoming childhood frustrations and dependencies, for "standing outside of one's self" (what help is offered here by a sense of humor!), for understanding that, necessary as it is to rebel in order to achieve freedom, the best freedom lies in the growing capacity to take a hand in the more affirmative process of self-development. Clarify your goals. Get the joy of fulfilling your own potencies. Change discipline from without to self-discipline. Will religion help? All depends on whether it is a flight from reality or a courageous attempt to understand reality better.

"Paul Tillich, writing from the theological view, makes the point that despair and anxiety can never be worked through until one confronts them in their stark and full reality. This truth is obviously just as valid psychologically. Maturity and eventual overcoming of loneliness are possible only as one courageously accepts his aloneness to begin with" (p. 203).

"Religion is constructive as it strengthens the person in his sense of his own dignity and worth, aids him in his confidence that he can affirm values in life, and helps him in the use and development of his own ethical awareness, freedom, and personal responsibility" (p. 205).

"Allegorically, the individual's decision is like that of the Israelites in their battle against the army of Sisera: 'the stars in their courses fought against Sisera,' but not until the Israelites decided to fight, too" (p. 220).

Hence Dr. May regards man's chief resource as courage, which he defines and illustrates mainly as moral courage:

"The opposite to courage is not cowardice; that, rather, is the lack of courage. To say a person is a coward has no more meaning than to say he is lazy; it simply tells us that some vital potentiality is unrealized or blocked. The opposite to courage, as one endeavors to understand the problem in our particular age, is automaton conformity. . . . What is most dreaded is getting out of the group, 'protruding,' not fitting in. People lack courage because of their fear of being isolated, alone, or of being laughed at, or rejected. If one sinks back into the crowd, he does not risk these dangers. And this being isolated is no minor threat. . . . One of the reasons creative activity takes so much courage is that to create stands for becoming free from the ties to the infantile past, breaking the old in order that the new can be born" (pp. 225, 226, 228).

"In my clinical experience, the greatest block to a person's development of courage is his having to take on a way of life which is not rooted in his own powers. . . . Normally a child can take each step in differentiation from his parents, each step in becoming himself, without unbearable anxiety. Just as he learns to climb the steps despite the pain and frustration of falling back time and again, and eventually succeeds with a laugh of joy, so he normally feels out his own psychological independence step by step. . . . What he needs is neither overprotection nor pushing, but help to utilize and develop his own power, and most of all to feel that his parents see him as a person in his own right and love him for his own particular capacities and values" (pp. 231, 232, 233).

May's interest in literature would please Theodor Reik, who has been saying—e.g., in *The Secret Self*¹—that some of the most valuable insights into the psyche come to people who add to their professional training an understanding love of first-rate books. (Freud drew on Greek literature for the very names Oedipus, Electra, Narcissus.) The many literary illustrations employed by May are useful enough to make one wish that more American practitioners enjoyed the education in literature that we have come to expect of Europeans.

One example, on the topic of the book under review, is found in a bit of autobiography by Theodore Roosevelt. In a novel by Captain Marryat, he read about a brave sailor who said, "By acting as if I were not afraid, I gradually ceased to be afraid." This is the practical application of the Lange-James theory of emotion popularized by William James more than half a century ago: in some situations, performing the acts essential to playing a part may do much to arouse the very feelings that move to such actions. Why this recommendation is not offered more frequently to-day is somewhat puzzling. While of course acting like a brave person may induce a certain amount of courage when a person knows just what he fears, it may also have a certain usefulness, at some stages in the therapy, for other types of fearful person, too.

HENRY NEUMANN

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IN SEARCH OF SELF. By Arthur T. Jersild. New York: Bureau of Publications, Teachers College, Columbia University, 1952. 141 p.

This important contribution to mental hygiene is unusual in many respects. For once, the notion of the self concept is treated in simple and understandable language without pretentiousness. A research study is reported in a forceful manner without a maze of statistics. An important and highly skilled rôle is assigned to teachers and others

¹ New York: Farrar, Straus, and Young, 1952.

who work with boys and girls, without frightening them with a stream of professional jargon and impressing them with their inadequacies. Jersild emphasizes the need for self-understanding on the part of the teacher, rather than professional qualifications of a highly technical nature, for the psychologist rôle he so unflinchingly assigns to the teacher.

Although he does not treat the issues related to the use of psychological tests in developing self-understanding, he definitely uses an approach quite different from that of the advocates of the "test them, tell them, and they know" technique. The author takes the point of view that children have more capacity for understanding themselves than educators have ever realized, a point of view supported by his own findings as well as by those of others.

The first part of the book deals with the nature and underlying theory of the study. The second part is concerned with the following concepts used in self-evaluation: personality, character, inner resources; self-control; social attitudes and relatedness to others; relationships with the opposite sex; intellectual abilities; home and family; physical characteristics; clothing and grooming; special talents, sports, recreation, health; and religion. In the final section, the author tackles the important problem of the school's rôle in helping the child to achieve self-understanding.

The book will disappoint many teachers and teacher trainers by its failure to offer specific suggestions as to how teachers can achieve self-understanding and how they can assist their pupils in achieving such understanding. Jersild warns in his preface that he is writing about an idea that is still in the process of development. Although it is easy to accept the validity of this explanation, it is not so easy to excuse the author for creating a strong readiness for information that he does not give. Surely, after his study of this problem and with his rich background of experience, he has formulated some rather specific ideas as to how the objectives that he so ably espouses can be achieved. Lacking these, he could at least have resorted to ideas and research findings that have already been reported in the psychological literature of this subject.

Of the omissions in the list of concepts chosen by Jersild as important in self-evaluation, perhaps the most serious is that of the occupational rôle. Perhaps the most confusingly presented of these concepts is that of intellectual abilities. The author might well have drawn upon the research of others to clarify to some extent some of the puzzling problems he uncovers in this area.

Despite these limitations, Jersild has performed an extremely important service by emphasizing the importance of the individual's

understanding and accepting himself, and of the school's rôle in fostering this process.

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THE CONDUCT OF LIFE. By Lewis Mumford. New York: Harcourt, Brace, and Company, 1951. 342 p.

There seems to be rather general agreement among the best writers of this century that our civilization is in a very bad way. The conclusions of these thinkers are strangely and disturbingly similar. The details of causation and the nature of the decline may vary somewhat from writer to writer, but the central theme is found everywhere: Western culture is sick unto death.

Some thinkers of the nineteenth century felt and foretold the crisis (forgive the overworked word, but it still has meaning) that was approaching, but in the main, these were isolated voices in a century of oversimplified optimism. There is hardly a thinker of the first magnitude in the twentieth century who has not joined the voices of those who utter a solemn warning. The mention of a few of the great books of this period will suffice to recall their thought and message: Spengler's *Decline of the West*, Schweitzer's *The Philosophy of Civilization*, Ortega's *The Revolt of the Masses*, Sorokin's *The Reconstruction of Man*, Toynbee's *A Study of History*, Hocking's *What Man Can Make of Man*, and so on.

In 1934, Lewis Mumford published the first of four volumes designed "to deal in a unified way with man's nature, his work, and his life-dramas, as revealed in the development of contemporary civilization." These volumes have now appeared under the following titles: (1) *Technics and Civilization* (1934); (2) *The Culture of Cities* (1938); (3) *The Condition of Man* (1944); and (4) *The Conduct of Life* (1951).

Although all of these books deal with the critical situation of modern man and the background of that situation, the last in the series, *The Conduct of Life*, brings the problem to final focus, as Mumford sees it. This volume is thus another book in the tradition of the other great books of this century that attempt an analysis of Western man's central problem. The conclusion is essentially the same: Modern man is in dire straits. But Mumford is convinced, in the face of the frankest look at modern man's condition and a careful examination of his limitations and potentialities, that man can renew himself and his culture and enter into a rich and full life. In short, there is

thoughtful hope in this book—a quality relatively rare in our times.

Because of its insight into the condition of our culture and of the individuals who compose that culture, *The Conduct of Life*, in my judgment, is a great book in mental hygiene. In fact, this volume is a much better study of the problems of mental health than most books claiming to deal directly with that complex subject. All those who have an interest in mental hygiene and who have the educational background to do more than surface thinking on the subject will find Mumford's treatment extremely rewarding.

The author has organized his subject into the following nine chapters, the titles of which will give the prospective reader some hint of the treatment; Chapter I. *The Challenge to Renewal*; Chapter II. *Orientation to Life*; Chapter III. *Cosmos and Person*; Chapter IV. *The Transformations of Man*; Chapter V. *The Basis of Human Development*; Chapter VI. *Beyond Moral Ambiguities*; Chapter VII. *The Fulfilment of Man*; Chapter VIII. *The Drama of Renewal*; Chapter IX. *The Way and the Life*.

The subtitle on the jacket of the book, *The Renewal of Man*, in a sense states its central topic. The development of the subject is as follows: The first chapter describes the potential of modern man, his present condition, and the possibility of and dire need for renewal. Although there is no promise of an easy solution, of the three alternatives suggested for man, one is individual and cultural renewal, which the author considers not only possible, but perhaps imminent. The other two alternatives lead to certain extinction. They are (1) a continuation of Western man's present course of overmechanization and, hence, dehumanization; and (2) a regression and crystallization of cultural forms in a dictatorship that seeks to forestall through force the inevitable deterioration. This second course is the general pattern followed by countries such as Nazi Germany.

The remainder of the book makes a detailed analysis of what is necessary for the renewal of man. Chapter II shows how renewed man must be related to organic life, and Chapter III, how the healthy person must be related to the cosmos—that is, to "the big questions." Chapters IV to VIII analyze with great skill how personality is formed and transformed. The final chapter is a delightful presentation of practical procedures in daily living necessary to the renewal of personality, or, in other terms, to good mental health.

The greatness of the book from the mental-health point of view results largely from the author's appreciation of the complexity of man's nature. The breadth and depth of all human learning are brought to bear upon the problems of the conduct of life. No single science can hope to give man the knowledge and wisdom he needs to develop wholesome personality. There must be a new science of

man, using the resources of all sciences and indeed of all arts, if man would discover and use the truths that would save him from personal and cultural disintegration. Mumford has focused a lifetime of study and learning upon the problem of man's personality. In so doing, he says many wise and insightful things.

Every thoughtful reader of *The Conduct of Life* will find points, some of them fundamental, with which he disagrees, but in that disagreement thought will be provoked. Perhaps enough of such thought will do something to enable the renewal of man, so desperately needed in our time, to take place before man destroys himself.

E. V. PULLIAS

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A SEX GUIDE TO HAPPY MARRIAGE. By Edward F. Griffith. New York: Emerson Books, 1952. 346 p.

Interest in the various aspects of marriage and family living is increasing, due to the desire of men and women to find security in this interpersonal relationship. They expect more than men and women ever did, but are not necessarily equipped to give to it what it requires. Whatever contributes to this knowledge is of great help in the many adjustments to be made in marriage. There is still too much taboo and superstition, in the area of sex and reproduction, a good deal of ignorance and misinformation, and a vast region still not clarified for those who are professionally concerned in these fields.

In England, too, this interest is manifested by the many books written for lay people. Dr. Griffith, in his book, *A Sex Guide to Happy Marriage*, deals thoroughly with the subject of sex and reproduction. The book is a revision of one originally written in 1935 and is the American edition of the earlier British one. The author has included in this volume facts not only about his own country, but also about resources available in the United States.

He describes clearly and realistically the anatomy and physiology of the sex organs, the problems of engaged couples, contraception, sexual relations, sex problems, infertility, and sex education. A special chapter on marriage counseling in the United States was written by Dr. Robert Laidlaw and Frances Dow. The appendix gives an excellent guide to family-council services, marriage-counseling services, and planned-parenthood services in the United States.

In one chapter the author deals with the mind and emotions, showing an awareness of some of the newer concepts of human behavior. But throughout his work Dr. Griffith does not show true understanding of human behavior—how these concepts are, and should be, applied.

He calls people stupid, spoiled, selfish. "I condemn their attitude," he says, in discussing "parents who consider it the duty of the child to stay at home" when they are ready to leave it. Again, he states, "Scarcely a week goes by that I do not see at least one person who has made a hash of her life through this sort of stupidity," referring to premarital sex relations without adequate contraceptive measures. He discusses behavior and its development early in life and yet, in describing adult behavior, does not show understanding of motivations. He gives advice that some people could not possibly follow because of early experiences that make it impossible for them to react in an adult manner.

In the United States we have developed sufficiently in our understanding to expect books of this nature to be not only informative, but, above all, to be non-judgmental.

LENA LEVINE

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PRINCIPLES OF INTENSIVE PSYCHOTHERAPY. By Frieda Fromm-Reichmann. Chicago: The University of Chicago Press, 1950. 245 p.

In this volume Dr. Fromm-Reichmann has presented a sensitive and provocative report of her many years of experience in the practice of psychoanalytic psychotherapy. She takes up in detail the way in which a therapist should behave in the first interview, with emphasis on listening as a basic psychotherapeutic instrumentality. After this, she goes into considerable detail with regard to methods of interpretation and to ways of meeting the various crises encountered in therapy. She offers practical suggestions supported by brief examples from case material. She has succeeded in providing a book of great practical value to any one concerned with the practice of psychotherapy.

As an admirer of H. S. Sullivan, Dr. Fromm-Reichmann is an exponent of the theory that psychotic illnesses are primarily psychogenic in origin. She states: "It is my belief that the problems and emotional difficulties of mental patients, both neurotics and psychotics, are, in principle, rather similar to one another and also to the emotional difficulties in living which we all suffer at times."

Psychiatry and psychotherapy are defined as the science and art of interpersonal relations. Dr. Fromm-Reichmann also accepts H. S. Sullivan's term, "parataxic distortions," and his use of transference and countertransference in the most general sense of those words.

It is noteworthy that Dr. Fromm-Reichmann modifies many of the Freudian concepts. For example, on page 99, she concludes that an unresolved Oedipus constellation is not a ubiquitous etiological factor

in the pathology of mental disorders. For this reason, it follows that it is not always possible to find Oedipus love and hatred for the psychiatrist in the interpretive picture. "They are conditioned by carry-overs of a person's previous interpersonal experiences prevalent from infancy and childhood, but not always or necessarily from entanglements with his parents."

The author lays a great deal of stress on leading the patient to improve his capacity for reality testing. For example, she makes the point that "wherever possible, psychotherapeutic considerations should also include the interpretive investigation of the patients' transference experiences in terms of their presenting problems and their recent crisis situation."

The practical manner in which she illustrates by ingenious examples the ways of meeting hostilities and other forms of resistance in patients and their families is a valuable feature of the book.

Unfortunately, in common with other books on psychotherapy, the book has very little to say about the end results of therapy. The implication is that a majority of patients did well, but there is little about failures or how to avoid them. The reviewer hopes that out of her many years of experience Dr. Fromm-Reichmann will soon let us know in some detail what results have been secured by intensive psychotherapy of a large number of psychotic patients.

EDWIN F. GILDEA

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THE YEARBOOK OF PSYCHOANALYSIS. Vol. 7. Edited by Sandor Lorand, M.D. New York: International Universities Press, 1951. 271 p.

This volume runs the gamut of psychoanalysis, from its genesis in Freud (see Herman Nunberg's *A Commentary on Freud's "An Outline of Psychoanalysis"*) to its application in sociology and interpretation of contemporary literature (in *The Oedipus Trilogy*, by Mark Kanzer) as a reflection of contemporary practices, beliefs, and myths. It is rounded out by Otto E. Sperling's *Psychoanalytic Aspects of Bureaucracy*, which depicts the bureaucratic personality, always more or less with us, and the political philosophy inherent in it, which smacks of authoritarianism. Interspersed are articles by Benedek and Greenacre, centered upon physiological trends and phases and their concomitant repercussions upon the psychic state.

It is difficult to single out any one article for special excellence, for all indicate scholarly and broad cultural interests, and the literary style of most of the contributors is commendable. One is

also struck by the wholesome variance of opinion, the search for new concepts, and the reëvaluation of older, traditionally accepted concepts. Fliess, in *The Revival of Interest in the Dream*, is an excellent prototype of this category.

If we mention only a few in this Hall of Choice, we are sure that those who are familiar with the other contributors—Ernst Kris, N. Lionel Blitzsten, Ruth S. Eissler and K. R. Eissler, Heinz Hartmann, Edward Glover, Raymond de Saussure, W. Hoffer, Leon J. Saul, Michael Balint, C. P. Oberndorf, Richard Sterba, John Rickman, Edith Buxbaum, Ralph R. Greenson, Martin Wangh—are aware that the selection has been a representative and laudable one. In as much as these articles have been published in current periodicals on psychoanalysis, in all likelihood many readers will already be familiar with their contents.

EDWARD LISS

New York City.

CASE HISTORIES IN PSYCHOSOMATIC MEDICINE. Edited by Henry H. W. Miles, M.D., Stanley Cobb, M.D., and Harley C. Shands, M.D. New York: W. W. Norton and Company, 1952. 306 p.

This book is a good companion volume to Cobb's recently published *Emotions and Clinical Medicine*, presenting case examples to illustrate many of the principles formulated in the latter text.

There are twenty-one cases, averaging about twelve pages to a case, which indicates correctly that there are no lengthy, too detailed case presentations. This may be taken by some as a disadvantage, among other characteristics of the book, such as the obvious condensations and summaries both of history and of group presentations, the frequent lack of pertinent interview material, and the apparent neglect of thorough dynamic background information. But though, on first perusal, these features may seem to detract from the book's value, on further consideration it becomes evident that this is by no means the case and that the original purpose of the book would undoubtedly have been defeated by a different sort of presentation.

This is not a book meant primarily for psychiatrists, psychologists, and psychoanalysts; it is not a technical or a complicated book. It was written for the physician who is most interested in patients as people, whether he be general practitioner, internist, surgeon, or dermatologist, and as such, it had to be written in a fairly simple, easy style, free from the technical psychiatric lingo that so often tends to avert the interest and attention of the average medical reader. Psychiatrists and many psychoanalysts are now fairly well aware that technical psychological language—especially some of the too

easily misused Freudian phraseology—is often like a red flag to bull when it is tossed out into a circle of medical students or doctors in general.

Stanley Cobb's case presentations do not fall into this trap. The dynamic interpretations, although by no means complete, are clearly understandable and acceptable, do not jump to unwarranted conclusions, and are expressed in non-technical, although accurate language. A refreshing variety of medical problems are included, as the following headings will indicate: "Psychogenic Deafness in a Disturbed Boy," "Impulsive Behavior in a Crippled Boy (Osteomyelitis)," "Feeble-mindedness or Pseudoretardation," "A Child's Reaction to Adenoidectomy," "Convalescence in a Patient with Permanent Neurological Disability," "Painful Myostatic Dystonia," and "Epilepsy and Temporal Lobe Abnormality."

The collection is heartily recommended to those interested in the practical aspects of psychosomatic medicine. There is repeated emphasis on the importance of psychotherapy in any medical disorder, regardless of its etiology, with the idea that patients are people who react to illness with a variety of emotional and personally determined attitudes, many of which complicate their symptomatology and interfere with their convalescence. Unless these attitudes are taken into consideration in the over-all treatment program, there is liable to be faulty diagnosis as well as failure to respond to ordinary methods of therapy.

HARRIOT HUNTER

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PSYCHOANALYSIS AND GROUP BEHAVIOR. By Saul Scheidlinger. New York: W. W. Norton and Company, 1952. 245 p.

This book represents an analytical study of the motivating forces that underlie group behavior. Main consideration is given to Freud's original views on the subject, but the opinions of his followers also are carefully aired.

The first chapter is devoted to a discussion of the various theories concerning the origins of the gregarious tendencies of man. A condensed Freudian formulation of the psychological development of the individual follows. The author discusses the various factors that influence the degree of relatedness of the growing individual to the various persons who are closely associated with him during the formative years of his life. He reiterates the well-recognized fact that the emotional ties existing within the family group constitute the foundation upon which social relationships are later built.

Group dynamics thus not infrequently resemble those of the family.

The leader of the group becomes symbolic of the parent figure. The various tensions originally manifested in family relationships once again seek expression in the interpersonal relationships of the group. Libidinal ties, jealousy, aggression, and fear, as well as the mechanism of identification, all play a decisive rôle in group action. The way these elements are handled by the members of the group determine the direction of the growth of the group, its positive or negative achievements.

The author discusses the application of the Freudian concepts to the fields of social group work, education, and group therapy. He stresses the importance of tapping and clarifying the emotional needs of children, so that they may be enabled to achieve more harmonious social relations later in life. This can be brought about only by skilled teachers who possess a thorough knowledge of dynamic psychology.

He reviews briefly the existing methods of group psychotherapy, quoting the contention of some psychoanalysts that the basic relationship between the therapist and the single patient constitutes in essence a group-therapy setting. The core of the psychotherapeutic relationship, identification with the leader, is true of the larger group setting as well. Early family conflicts are often reactivated in the group psychotherapeutic sessions and are of aid in clarifying the patient's attitude toward his current problems.

The author quotes freely the various, at times conflicting opinions of the many adherents of the Freudian school to illustrate the fact that we have not yet reached a full understanding of the complex forces underlying group, as well as individual, behavior. He advocates further study and research, feeling that only through greater understanding of our motivating forces can we hope to reach a more rational attitude toward our fellow man.

It is regrettable that the vast experience in group relationships and especially in group psychotherapy in the armed forces reported in the literature during World War II has not been incorporated in the book. In general, however, the subject matter has been well handled and the book constitutes a work worth while reading.

SAMUEL PASTER.

Memphis, Tennessee.

THE ATTITUDE THEORY OF EMOTION. By Nina Bull. New York: Nervous and Mental Disease Monographs, 1951. 159 p.

The confusion and fear in which man lives to-day threaten not only the individual, but the survival of the human race. Man's compulsions and frustrations impose on him against his conscious will a distorted picture of the world in which he lives. A new light is thrown

on this alarming situation by a revolutionary theory of emotion presented by Nina Bull in her book, *The Attitude Theory of Emotion*. Mrs. Bull was formerly research associate in psychiatry at the College of Physicians and Surgeons, Columbia University, and has been carrying on a research project in the study of body attitudes in emotion for the past twelve years at the New York Psychiatric Institute.

How shall man reach an understanding of himself that will free him from the blind motivations that impel him toward destruction? What exactly are the emotions of fear, anger, disgust, depression, which govern so much of his behavior? What is the mechanism of an emotion? Although the need for a scientific principle to explain emotion has long been recognized, there has never been one formulated that has met with general acceptance among psychologists and psychiatrists. The popular belief has always been that emotion is a state of feeling, followed by expression. This new theory claims that there is a body attitude that comes before feeling.

The eminent neurologist, Dr. C. Judson Herrick, who writes the introduction, considers this book "a significant contribution toward an understanding of the motivation of human conduct," and urges that attention be paid to it. The writing is simple and clear, scientifically concise, and the author employs no newly coined words to add to the prevailing confusion of psychological terminology.

Nina Bull's concept of emotion is of a dynamic process, the first step of which is a preparatory motor attitude. This attitude gives rise to feeling, and may or may not be followed by action. The "motor attitude" is explained as an unconscious bodily preparation for some special kind of action and it involves the entire neuromuscular system. Feeling is awareness of this preparation (which includes organic changes in heart action, breathing, gland secretion, and so on) and follows motor attitude.

For example, in a situation that arouses hostility, a bodily preparation to fight is set up, with tensing of the arms and hands to attack. It is only then that the feeling of anger is experienced. Thus by the time a *feeling* of anger is registered in consciousness, some bodily preparatory action is already under way. An awareness of this physiologic preparation is shown in colloquial phrases such as "hot under the collar," "his back was up," "fixin' for a fight," and so on.

A series of diagrams is used in the book which help the reader grasp the basic sequence: motor attitude, feeling, consummatory action. When the motor attitude becomes conscious as a feeling of direction and intention, it is spoken of as mental attitude. This fits into the basic sequence as part of feeling.

By separating action into the two phases of preparatory and con-

summatory action, the writer posits a delay, which she states is essential to emotion, as it is during this delay period that feeling arises. In some forms of behavior, in which the person reacts immediately to a situation, there is no delay and hence no feeling. However, whenever emotion is experienced, there must be some delay in action. It is this suspended preparation, as of a coiled spring ready for release, that gives a person his feeling of "suspense." Often the sensations of organic changes involved in motor attitude appear in consciousness without a clear-cut feeling of direction and intention and are experienced as restlessness, nervousness, tension, or vague excitement.

In conflict, delay is caused by a secondary motor attitude's swinging in before the first has reached the stage of action. Anger, for instance, is often interrupted by fear, which contains the impulse to turn and run away, and blocks the forward-moving impulse to attack. Thus each of the reactions blocks the other and keeps it in its preparatory stage, inhibiting its consummation. These conflicting attitudes lead to confusion in the realm of feeling and always paralyze action to some extent. Psychosomatic symptoms are often the result. But according to the author, the intricate process known as *thinking* also has its origin in conflicting attitudes, and represents an attempt to solve problems too complex to solve without it. Incompatible attitudes become less mysterious in the light of *attitude theory*, which clarifies them as primarily motor in character. In other words, the struggle felt in all emotional conflict is muscular.

The attitude theory is supported by a number of experiments carried out at the Psychiatric Institute. A large section of the book is devoted to the reporting of these experiments, which were worked out in collaboration with research psychiatrists and psychologists.

The purpose of one series of experiments was to demonstrate whether or not a given feeling has a characteristic motor pattern. Volunteer college students, men and women, were selected as subjects, and hypnosis was used as the experimental procedure because its freedom from self-consciousness offered the best chance of producing uncomplicated or "pure" emotions. The subjects were commanded to experience a certain emotion in response to a stimulus-word, say "disgust," and their observed behavior, together with subjective reports of their feelings, were recorded and compared. It was found that as they felt the induced emotions of disgust, fear, anger, depression, triumph, and joy, they assumed definite behavior patterns which were consistent for each emotion.

A following series of experiments demonstrated in a striking manner the inevitable linkage of specific patterns of behavior with specific kinds of feeling. The method used was a "locking" (hypnotic

fixation) in the physical set of one emotion, after which a command to feel a contrasting emotion was given. Invariably the subjects could not feel the new emotion while the body was held in the postural set of the first. If a shift did take place and the new emotion was felt, there was also a change in the postural act to correspond with the new feeling.

There are many illuminating observations on all the emotional patterns studied. The behavior in *depression* is particularly interesting as stemming from frustration, or interference with goal orientation. In view of the widespread sense of frustration to-day among nations as well as individuals, an understanding of this frustrated attitude would clarify much enigmatical behavior.

Other thought-provoking studies in this book center on the dual character of fear, the orienting function of vision, emotion as communication, the contagion of horror and hate, posture and facial expression as body-language, and the olfactory drive in dislike reactions. A long chapter is given to the forerunners of the theory, and a number of scientists are quoted as having to some extent anticipated it. In Dr. Herrick's introduction, he states, "The difference of interpretation of the observed facts as reported by James, Lange, Cannon, Sherrington, and many others are reconciled in Nina Bull's attitude theory, which is documented by ample experimental evidence."

The formulation of the attitude theory of emotion is an important scientific achievement. It explains scientifically for the first time the relationship of feeling to action. It offers a basic psychologic principle which may well be the key to a new appraisal of human behavior, making it more intelligible, and opening the way to modifying it. There is no possibility of free and intelligent choice of action while we are self-prisoners of our hidden compulsive attitudes and resulting frustrations. Only by bringing the unconscious motor attitude into mental awareness can we channel it toward purpose and direction. As Mrs. Bull points out in her preface, attitudes determine thought as well as feeling and action, and we have to find a way to change attitudes if the human race is to survive.

It is to be hoped that the rich material in this book will be expanded and put into more popular form. In the meantime, it is the belief of this reviewer that a careful reading of the present volume will be rewarding to all who find significance in the outline of the theory presented here.

MARIE MCCALL

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DON'T BE AFRAID OF YOUR CHILD. By Hilde Bruch, M.D. New York: Farrar, Straus, and Young, 1952. 297 p.

In the last chapter of this book, Dr. Bruch confesses that throughout she has mistakenly been addressing herself to "the modern parents of yesterday" instead of to the modern parents of to-day. She devotes the chapter to affirming her faith in the courage, independence, and good judgment of the modern parent.

This anachronistic situation, however, does not obviate the need for much of the advice Dr. Bruch offers. All parents—whether of the old-fashioned behaviorist school, or the more recent over-permissive type, or even the modern young parent whom Dr. Bruch so admiringly extols—can benefit from her psychologically sound main thesis and from her thought-provoking challenges to commonly accepted practices.

Dr. Bruch believes that a child's emotional well-being depends directly on the emotional well-being of the parent. Any factor that makes for a feeling of guilt on the part of the parent, lessening her self-confidence, will necessarily be reflected in the parent-child relationship and impair the child's feeling of security.

She goes on to indicate the self-defeating elements in those very institutions created purposely to improve the parent-child relationship. According to her, even planned parenthood, for example, is not the unmixed good it appears to be. By assuming for herself the power to determine whether and when another human being shall be created, the parent becomes the self-conscious bearer of an awesome burden of responsibility which may unduly undermine her spontaneity of behavior and her self-confidence.

Similarly, the author indicates that when a mother cannot, for one reason or another, take advantage of strongly recommended practices such as "natural childbirth," the "rooming-in plan," or breast-feeding (practices that may perhaps have been overrated), a feeling of guilt develops, with resultant uneasiness. By the same token, Dr. Bruch feels that utter disregard for the needs of the mother, physical or otherwise, in favor of the child's welfare, is self-defeating. To use her own words, "In order to be a good mother to one's child, one must be good to oneself."

Other generally accepted theories that come in for criticism are self-demand feeding, leniency in permitting a child to choose his food, and deferred toilet training. In discussing these, the author seems to be quite in harmony with many of the other modern "experts" on the desirability of steering a middle course. In the case of the older child, she criticizes the abnormally high value that modern education places on social adjustment and popularity, with its resultant tendency to discourage intimate friendships and induce conformity to the group

rather than the fulfillment of the child's special personality and talents.

Without minimizing the need for guidance in exceptional cases, much stress is placed on the dangers inherent in the application of the generalized advice of "experts" and on the fact that psychological help can best be obtained individually. Since human problems and relationships are subtle and complex things and by their very nature extremely individual, any generalized prescription lends itself easily to misinterpretation and misapplication. The book, therefore—and especially because of the dynamic and changing nature of the science of child psychology—is a continual exhortation to the parent to use and have faith in her own good judgment rather than in the findings of experts.

Such advice might well be warranted if the heart of every parent were in the right place. But here Dr. Bruch seems to step out of her rôle of psychiatrist. She seems to ignore the teachings of psychoanalysis that much of human behavior is governed by subconscious influences; that genuine, unconditional love on the part of a parent is not as common as one would suppose; and that much that is actually reprehensible frequently appears in the guise of love. To this reviewer, it seems that as long as there is the natural emotional involvement with their children that makes objectivity difficult, it may be dangerous for parents to rely wholly on instinct in dealing with their children. Moreover, to do so would be quite as foolish as to create fire in this day and age by rubbing two stones together. To tell parents who have already been alerted to the findings of child psychology to ignore those findings, is tantamount to asking those who have the ability to see to blind themselves. It seems that much of Dr. Bruch's energies might perhaps have been better directed in exhorting parents to use their judgment in weighing and applying the principles and theories of the newer psychology instead of urging them to use their judgment and ignore those principles. For an educated guilt-ridden parent—and there are ways of dissipating guilt feelings—may be a lesser evil than an ignorant parent without guilt feelings.

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BETTER HOME DISCIPLINE. By Norma E. Cutts and Nicholas Moseley. New York: Appleton-Century Crofts, 1952. 314 p.

This book is based on answers received from over 6,000 families to the following questions: "What is the last thing a child of yours did that you did not approve? What did you do about it? What effect did your action have?" Children were asked to answer: "What is

the last thing you did that your parents thought you shouldn't have done? What did they do about it? What effect did it have?"

Being a careful summary of the answers, perhaps the book's greatest value is in giving a broad sample of what is actually going on in American homes to-day in the matter of child-rearing. While these answers deal with children of between two and seventeen, and always indicate the sex and age of the child involved, one is given no inkling of the educational or economic status of the families involved. Therefore, as a sociological study, it is less valuable than those by Allison Davis and others, which indicate great differences in discipline methods at different socio-economic levels.

As a means of helping parents to better home discipline, it seems to this reviewer to have less value. One of the authors' major objectives is served well—that of giving parents "the reassurance of knowing that most children misbehave in the ways theirs do, that most parents use the same punishments they use." All would agree that such "dilution therapy" has value in reducing the tensions that interfere with "better discipline," but not as a means of giving sanction to undesirable methods. Yet, as presented here, the total impact of the various forms of "This is what worked with my child," does seem to give such sanction. One fears it may do much the same kind of damage as "Spare the rod and spoil the child," which has sanctioned countless parental hostilities for centuries.

Webster says: "Discipline is treatment given to a learner." But most present-day parents, including those who answered these questionnaires, have little systematic preparation in the art of teaching—that is, in the treatment most helpful to learners. Thanks in large measure to the almost universal use of the pocket edition of Dr. Spock's excellent book on early child care, treatment of small children has greatly improved. This is reflected in this volume also. But through the school years—as indicated here, and as widely recognized by many parent-education and guidance workers—home treatment of school-age learners is too frequently less enlightened and growth-promoting than that in even average schools to-day. More and more teachers have had exposure to the principles of child growth and adjustment and the laws of learning, of which many parents, including some who hold higher degrees in unrelated fields, seem surprisingly ignorant.

With a warm teacher-pupil relationship and with motivation based on knowledge of developmental levels and individual capacities as the foundation of all good learning in schools, punishment is negligible as "treatment given to a learner." Spanking in schools is now against the law in the great majority of states except for most exceptional cases, and then approval for it must be given by both principal

and parents. Yet, in the parents' answers given here, punishment is the "teaching" method reported in the overwhelming majority of cases. Depriving of possession or privilege was most frequent, and next came spanking.

Any one who knows present home practices is not surprised at this. Unfortunately these practices are at least half a century behind those current in good schools. Therefore, the presentation of methods of discipline as, on the whole, acceptable if they meet the sole criterion of "it works," is deplorable. It is wise, of course, in teaching persons of any age, to start with them where they are, but we do not end there, or no progress, no real education has taken place. Education derives from words meaning "to lead forth."

Upon looking into Chapter I, *Does your Child Mind?*, one hopes that the presentation of what parents are doing is simply this acceptance of them where they are in order to help them grow into wiser ways through discussion in this and following chapters. But such is not the case. Throughout the book, the writers seem to accept the parents' reports that various methods "work" as sufficient validation of them. While effectiveness in getting immediate results is certainly one measure of the soundness of any method, this aspect seems far less important than two others: first, the effect of the method upon the relationship between the parent (or teacher) and the child, and, second, the effect upon the child's total growth toward wholesome maturity.

It is true that in the foreword the authors state that the goal of discipline "is not obedience, but self-discipline." Yet, while this important goal is given specific treatment in a few scattered sections, it is almost completely snowed under in the text as a whole by considerations of what is most effective in securing obedience. The discussion of methods presented and the "rules of thumb" at the end of the first chapter even suggest that a more accurate title for the book would have been *Better Home Punishment!* The unfortunate popular concept that punishment is almost synonymous with discipline seems reinforced, not corrected.

When one reads "the reports show that punishment can serve a useful purpose without being harmful," and that the reports from the children *prove* (italics ours) that "if punishment is prompt and to the point and not too severe a child . . . at least means not to do it again," one cannot avoid the feeling that the appraisal is superficial. It is obviously not based either upon long-range study of the subsequent results in children's lives or upon immediate sensitivity to the possibly unwholesome results either in the present or in the future development of a child and his relationships.

A mother writes as follows regarding her eight-year-old: "The last

time I punished my son . . . was the most severe punishment I had ever administered—the strap! It was for deliberate disobedience. . . . I find that he displays affection more after this little episode, puts his arms around me, and gives me a quick kiss" (p. 9). The authors comment: "Such seeking for affection may, of course, mean a child feels insecure and is seeking reassurance . . . in any case when you have had to punish a youngster you should immediately let him know how much you love him" (p. 10). But there is apparently no realization that such treatment, given habitually, might establish the pattern that suffering must always precede expressions of deepest love, or that love can be served only through suffering, leading to adult masochism and the acceptance of sadism as normal, even desirable, in the mate.

The same lack of deep insight regarding possible motives and results seems evident in the following: "A spanking is quick to give and quickly over. Children dislike it. . . . It is often effective when other methods fail. When properly administered—i.e., by the bare hand on the bare buttocks—there is little danger of injuring a child. Your hand will sting enough to make you glad to stop" (p. 4).

Lack of injury to small bodies does not obviate injury to small persons' concepts of themselves as well as of parents who take advantage of their difference in size and seem to feel that force is the best teacher. Nor does it obviate the dangers of masochism just mentioned. Nor does the idea that punishment has been a universal method of child "training" (this word itself suggests what is more appropriate for animals than children!) as set forth here prove its validity. Neurotics and psychotics, delinquents and criminals have been produced in large numbers—"universally"!

One hopes, upon finishing this unpleasant chapter, that the tone of the rest of the book will be more warming and constructive, and one recognizes a sincere effort on the part of the writers to make it so. The very title of Chapter II—*An Ounce of Prevention is Worth Pounds of Punishment*—indicates this intention.

Yet the concept of punishment as the method (or prescription?) that "works" crops up again and again. Not only do we read in Chapter I, "Deprivation is especially good with older boys and girls because a girl wrote that missing the Y dance 'taught me not to answer back to my elders,'" but again in Chapter VI, *In and About the House*, we read: "Deprivation in one form or another seems to be more effective than other correctives" (p. 84). And, on page 89, we find "Certainly docking an allowance gets results," as indicated by the reports of many parents. And in Chapter XIII, *Observations on Methods of Discipline*, which is intended as a summary of the authors' evaluations of the methods discussed in the preceding chap-

ters, we find (p. 226): "Punish promptly, appropriately, and in moderation when *you* [italics ours] feel it is called for." As a final dictum, this seems to negate the concept of giving children a share in making rules, as suggested in the section on family councils. When this is really carried through and a child knows that he has broken a rule, he will often pay the penalty without being told, thus developing toward the self-discipline the authors agree is desirable.

Even in the otherwise good section on "making amends" for wrongdoing (p. 225), the opportunity that should exist in such a process for growth in self-direction seems largely missed. Parents are told to "insist" that the child make amends and see that he does it, instead of leaving it up to the child to think through and carry out in his own way. The parents are to "make [italics ours] the child earn money to pay for the damage or forfeit part of his allowance." By "making" the child, parents rob him of initiative, independence, and the opportunity to grow toward self-discipline. The most valuable part of any act of atonement is that it is self-imposed, not dictated by another.

Even the good "rule of thumb" on page 197, ending the chapter on "Teens and Pre-teens," which says, "Discuss matters with your boys and girls," continues: "Explain to them *your* attitudes" (italics ours); there is no suggestion of listening to theirs. It sounds more like a "talking-to" than a discussion! And, unhappily, here as always, the tone remains primarily at the "This is what works" prescription level. Even the title of Chapter XV—*Praise Works Wonders*—which is supposed to be most constructive, illustrates this. And in the content of this and other intentionally constructive chapters, such as *Play is Good Discipline* and *Fun with Family*, the concept of a fundamentally rich, warm, accepting parent-child relationship—in which mutual understanding, appreciation, and joy are inherent in daily living, not tacked on as methods "that work"—is never developed. Yet in this reviewer's experience and study, such a relationship is the foundation of all good discipline and should be the groundwork of a book called *Better Home Discipline*.

The authors do include a paragraph or two showing they have gone through materials that present this more fundamental approach, such as Baruch's *New Ways in Discipline*, which tops their book list at the back. They suggest, for instance, in one short paragraph, that "parents spend some time alone with each child each day, doing the things he likes to do." But little is said regarding the feelings that should lead to or enter into this "time alone." Parents are told further, "Show each child you love him completely," with no discussion of the real feeling involved or of the adjustments that may be needed before parents can love each child "completely," no honest

acceptance of the fact that many parents can't love all their children completely (equally?) every day because of inevitable ups and downs in their own feelings. It is simply handed out like a prescription.

Parents are told to recognize the causes of disobedience and to give "sincere praise" (like a dose of medicine) to meet the child's needs for attention and recognition. This important concept is merely a section in Chapter II, *An Ounce of Prevention*, instead of being repeated again and again as a part of all parent-child interaction, and therefore inherent in all discipline.

The concept of accepting a child's feelings is also brought in, but only in one short paragraph in the same chapter, as follows: "You can help him by letting him know that you know he is mad. You can say: 'I'm sorry. I know you are mad. I used to [italics ours] get mad myself.' You can also help him work off his temper by suggesting desirable things for him to do. But, in any case, you should remain firm and consistent in what you ask and forbid."

This seems to suggest that the parent may admit that he *used* to have such human feelings as anger, but that he has long since outgrown them all! Such a "holier than thou" attitude does not make for the feelings of warm, understanding "we-ness" that is desirable even in the setting of limits to expressions of anger where it is true that we must remain "firm and consistent."

Ways of developing feelings of genuine partnership between parents and children are not set forth here even in chapters that discuss family councils and family outings.

In spite of the many excerpts from children's answers to the questionnaires, one feels that the whole book is written from the adult's point of view. It seems that most of the children's answers, though anonymous, are unconsciously written in an effort to give the right, almost "goody-goody" answers for the adults who will read them. This is true not only of the small children's, which could not help being colored by the fact they were dictated to by their teachers, but of a surprising number of the adolescents'. There is an unhappy contrast with books in which children's real feelings are freely given. Here, there seems to this reviewer to be little of the *feel* of children's real feelings, in spite of the inclusion of some juvenile spelling. One eight-year-old girl writes, for instance, "I disobey my parents. My mother spanks me. It done me good."

There is no discussion of what lies behind the "talking back" that so many of the parents in this study feel they simply cannot "take" and proceed to punish severely. This the authors seem to accept as all right. They give no suggestion that some of this "back talk" might be a valuable source of understanding how the world looks to

the child and how he really feels about things, including his parents' treatment of him. Much of it would be more enlightening than the written answers!

It is unfortunate that the many negative aspects of the book tend to becloud the positive values, which are there also. The section on the family council, which ends Chapter II, has sound suggestions, such as "Planning things for fun should have as much emphasis as problems in council meetings," and "Be sure that each and every member has a chance to speak his mind."

The section on pets, including a résumé of Dr. Bossard's excellent article on their value, is good. So also is the suggestion in the section on household tasks that the child be shown how his help helps the whole family.

One likes also the following:

"Uninterrupted play, one psychiatrist says, is as refreshing as a good long-needed sleep" (p. 268). "If you are moving to a new house try to show it to him beforehand, show him where he'll sleep, give him a part in planning his own room. Also, take him ahead to visit the new school and meet his new teacher" (p. 289). "It is not just what you do for your children, but what you do together with them that counts" (p. 271).

In the last chapter, *Discipline and Mental Hygiene*, the emphasis upon seeking help with adjustment problems as readily as with problems of physical health, is good. However, in spite of the sound explanations that only behavior that is exaggerated, prolonged, or inappropriate for the child's age should cause concern, one feels that the list of possible symptoms might increase anxiety in already anxious parents. So, also, might the statement: "It is very hard for parents to believe they have actually rejected a child." The experience of this reviewer indicates that conscientious parents are often weighed down with the fear that they may have injured their child by inability to "love him completely" as they have been told (even in this volume) they must do. They need to be helped to see the ways in which they have and do feel and show love in spite of some evidences of rejection, so that they may come to accept themselves as they are and hence their child as he is.

Upon completing the volume, one feels that, on the whole, it does not guide parents more wisely than books written twenty-five years ago. Indeed, it seems to carry much of their flavor, in spite of the injection from time to time of a paragraph that presents sounder, more recent approaches. One cannot believe it will produce "better home discipline." For parents seeking help with discipline, one must choose every time, instead of this volume, Dorothy Baruch's *New*

Ways in Discipline, which will help them step forward into a more understanding, happier era for their children and themselves.

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CONTROLS FROM WITHIN. TECHNIQUES FOR THE TREATMENT OF THE AGGRESSIVE CHILD. By Fritz Redl and David Wineman. Glencoe, Illinois: The Free Press, 1952. 332 p.

This book is a report on the setting up and conducting of Pioneer House, a residential-treatment project. It might be described as a blue print for the residential care and treatment of over-aggressive children, whose rebellion against adult authority (at home, at school, and everywhere) is so extreme that they cannot be successfully treated in an outpatient clinic. As the authors describe (p. 17), "such children are not able to face up to fear, anxiety or insecurity of any kind without breakdown into disorganized aggression. . . . As for realizing what their own behavior contributes to a situation, how they provoke some one else or how they play into circumstances which are often to their own detriment—in this they are notoriously deficient. Whatever momentary awareness they may have evaporates so quickly that, if some one asks them thirty minutes later what happened, it is always some other person or some trick of destiny, as they see it, that is to blame for their plight."

Back of the behavior problems of these children is faulty ego development. Their egos do not perform the normal function of reality testing, but are engaged in producing arguments to justify impulsive, aggressive action. In the introductory chapter, there is a brief statement of the relation of the ego development of over-aggressive children to their behavior. Since this was presented in detail in an earlier book, *Children Who Hate*, the present volume logically is devoted chiefly to describing the kind of environment required for treating children of this type and the methods that have to be employed in their daily living in order to overcome the deficiencies in their ego development.

What was done with the children at Pioneer House, to help them build up capacity for inner controls of behavior, is set forth in painstaking detail. The psychological principles and the thinking that determined the approach to the children are clearly stated. The applications of these principles in dealing with the children in daily living situations in the treatment home are described with a wealth of illustrative material. One finishes the book with a better understanding of the difficulties inherent in setting up a treatment program for these over-aggressive children and with admiration for the patience and persistence of the people who carried it out. It is encourag-

ing to have evidence that children of this type can be helped, but discouraging to realize that, with all that was being accomplished, funds for the continuation of the home were unobtainable.

One could wish that *Controls from Within* might be read by persons engaged in institutional work with children and that it might have some influence toward modifying methods employed with so-called delinquent children in institutions. But in view of the kind of personnel that would have to be found in order to introduce such modifications, this is probably only a daydream.

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CURRICULUM DEVELOPMENT AS REEDUCATION OF THE TEACHER. By George Sharp. New York: Bureau of Publication, Teachers College, Columbia University, 1951. 132 p.

Even if a book did not carry its copyright date, one would frequently be able to guess the time of its writing accurately enough to be within a few years of its publication. This seems to be the case in the field of professional education, as well as in many other fields. One cannot evaluate this phenomenon as either good or bad. As a field develops, new ideas come in which themselves must be developed and which, therefore, receive more attention in writing than they would if they were already well-established aspects of the field. In the past several years, the aspect of human relations in educational administration has been brought more and more into the foreground until to-day almost every book published in this area is a book on human relations and administration.

In *Curriculum Development as Reeducation of the Teacher*, George Sharp has presented us with the human-relationship problems of the curriculum worker, who is more properly classified with administrators and supervisors than with classroom teachers. The job of the curriculum worker is not found in every school. As a matter of fact, most schools never have had a curriculum worker on their staff. However, with the growing belief that the school curriculum cannot remain forever the same, serious study has been made as to what the curriculum should be and as to how changes can be made so that benefit, rather than mere upset, will result. Many graduate students in education now train to become curriculum workers whose job it is to go into a school for a short or long period of time, depending upon the wishes of the employing school system, which, by the very fact that it employs a curriculum worker, announces that it wants its curriculum changed.

*This does not mean that every teacher in the school wishes the

curriculum—and, consequently, his ways of teaching—to be changed. Mr. Sharp is of the opinion that the vast majority of secondary-school teachers, the group upon whom he focuses, are exceedingly loath to change, will resent the curriculum worker, and be hostile and suspicious of him as well as of their school principals and supervisors. Quite properly, Mr. Sharp realizes that since the curriculum acts on the pupil via the teacher, the curriculum worker must concern himself with the reeducation of the teacher; and, again quite in line with modern theories of learning, Mr. Sharp emphasizes that such reeducation must concern itself with the personality of the teacher and with the personality relationships between curriculum worker and teacher. It is here that the author's conception of present-day secondary-school teachers enters to influence his picture of just what the task of the curriculum worker will be.

A further belief of the author is that most secondary-school teachers, even those who have been recently graduated from teacher-education institutions, follow the traditional conception of a curriculum—namely, that subject matter is of prime importance and must be imposed on the pupils. This is different from Mr. Sharp's view that the curriculum should be a "series of experiences which are guided in such a way that each child has a rounded program of living."

It is Mr. Sharp's opinion that teacher-education institutions must turn out traditional teachers in response to the demands of the traditional schools in which the vacancies are. Why such traditional schools, which employ only such traditional teachers, would seek the services of the kind of curriculum worker that the author describes as his ideal, is a mystery. It would also be intriguing to know how Mr. Sharp himself changed into a non-traditional teacher, but he does not use self-analysis nor does he discuss his own experience of reform. Instead, he turns mainly to writings in the fields of psychology and psychotherapy to get his answer as to how reeducation occurs.

As a matter of fact, he believes that the traditional teacher is in many ways similar to the "abnormal" person whom the psychiatrist treats and that, therefore, similar methods of reeducation can be used by the curriculum worker and by the psychotherapist. Both traditional teacher and psychiatric patient, claims the author, have been arrested in their growth, both are acting upon a set of static, routine habits without consideration as to their appropriateness or effectiveness, and neither is able to change by an act of will or by understandings obtained through college courses or through other such intellectual means.

Nevertheless, in spite of his distrust of college courses, Mr. Sharp does recommend that the curriculum worker guide teachers to sources that will shed light on the nature of society, of the young, and of

how the young become integrated into society. He names these sources as the fields of sociology, anthropology, child development, social psychology, mental hygiene, the psychology of learning, and even the philosophy and history of education.

One wonders why he does not trust present-day teacher-education institutions to use these fields for the "proper" education of prospective teachers. He sees even these new teachers waiting for the newer orientations until they become traditional teachers and get their chance to be reeducated by a curriculum worker.

The bulk of the book describes his reeducation of the teacher as taking place in large measure in an office in a school, where the curriculum worker sits and waits for teachers to drop in with their tales of woe, to which the curriculum worker is to lend a sympathetic ear in the manner of a nondirective counselor. These conferences must not start out on an intellectual basis. At the beginning, the curriculum worker must offer no ideas, discuss no ideas. The teacher will always have to relieve himself of some of his frustration in more or less violent expression before he can gain better ideas as to how to work with children.

"The reeducator," says Sharp, "is a sort of super-mirror that talks back to the individual, reflecting his thoughts so that the individual gets an increasingly clear picture of himself and his behavior."

Mr. Sharp allows the counseling in these sessions to be directive to the extent that the curriculum worker is to offer the teacher labels for the latter's feelings, labels that the teacher himself has not used. This must be what makes the curriculum worker a super-mirror rather than a mere mirror of the teacher's feelings.

How strongly the author believes that at their outset these individual sessions with teachers are psychological counseling rather than intellectual-educational sessions shows in his admonition that the curriculum worker should not get entangled in the intellectual content of what the teacher tells him. "Such an approach," he says, "is entirely out of place, for it defeats the very purpose for which the teacher came to him, namely to give vent to his feeling." The approach is always through feelings first, though in the end the curriculum worker, to be successful, must direct the teacher's attention to a rational definition of the problem with which the teacher came to him in the first place.

Mr. Sharp is of the definite opinion that the curriculum worker cannot be successful if he starts with the intellectual approach. One would like to know what the curriculum worker is to do if a teacher comes to him with a problem couched in intellectual terms with no directly verbalized feelings involved in the statement.

Besides the individual-conference phase of the curriculum worker's task, he has to attain the status of a leader in group meetings with teachers. In these group meetings, too, the author's emphasis is on the personality relationships, though there is some discussion of the techniques that the curriculum worker can use to get the teachers to understand the newer concepts of curriculum.

Here, again, the author considers the "suspicion and hostility" of the teachers to be the very first problem that the curriculum worker will have to face and work through. Any one who has worked with teachers knows that many are hostile to any one who is given any authority relating to changes in their teaching practices. The question arises, however, as to whether a person can act in the "objective, supportive, and accepting" manner in which Mr. Sharp wants his curriculum worker to act if he starts out with the notion that all teachers are strongly and deeply hostile to their administrators, to their pupils, and to changing. "Every one," writes the author, "has a 'vested interest' in continuing to behave as he is behaving."

Much of the value of this book lies at the point where its weakness also lies. The author brings together from a number of sources concepts that relate to reeducation. The discussions, however, are too much in the nature of describing what the authors quoted have said in a context other than that of curriculum development and too little an attempt to develop the adaptation of the listed ideas to the problems of the curriculum worker.

The close identification that Mr. Sharp makes of curriculum worker with psychological counselor is probably one of the reasons that have kept him from reconstructing psychological-therapy concepts to fit teacher reeducation. The psychotherapist is not involved with the work of his clients in the way that a curriculum worker is involved with the work of the teachers. Mr. Sharp himself emphasizes that the curriculum worker is brought to the school to change the teachers, and that the teachers know this from the beginning. Many of the teachers have not felt themselves to be in any kind of difficulty or distress until the curriculum worker's arrival on the scene.

The status position of the principal is practically ignored, yet his presence in the situation, making for a three-cornered relationship—teacher-principal-curriculum worker—alters the two-way relationship with which the author concerns himself.

Probably the most important contribution of the book lies in its two general themes—one, the importance of the human relationships involved in the task of any school worker, and the other, the theme that the curriculum worker's job is one that relates to the daily work

of each teacher as well as to helping the teachers forge a new curriculum for the school.

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THE DYNAMICS OF THE COUNSELING PROCESS. By Everett L. Shostrom and Lawrence M. Brammer. New York: McGraw-Hill Book Company, 1951. 213 p.

Not so many years ago, few were the Mt. Sinais from whence came the "thou shalts" and "thou shalt not's" for counselors and guidance workers. To-day, even my humble professional library bulges with counseling "commandments" issuing from the four corners of these United States. Some are good; some—not so good; some attempt to make an expert counselor of me "in ten short lessons"; some impress upon me the idea that I can never hope to know much about the complexities of counseling; some are worth the hard-earned money I put into them; some don't warrant the cost of the paper on which they are printed.

Where in that range of guidance literature does *The Dynamics of the Counseling Process*, by Shostrom and Brammer, fit? I place it on my bookshelf of good texts and consider my money well spent for a significant contribution to the theory and practice of counseling.

According to the authors themselves, the book is designed "to present a unified approach to educational-vocational-personal counseling and seeks to fulfill the need for a practical 'how-to-do-it' approach to counseling." And it does what it was designed to do.

Shostrom and Brammer attempt to accomplish this by presenting their theory of the "self-concept and its relationship to the counseling process" to begin with, and then going on to a discussion of "self-adjustive" counseling techniques in detail, based on a development or process approach rather than on the traditionally topical one.

Chapter titles map the road they travel. *Laying the Foundations*—the *Psychological Climate*, is followed by *Testing the Self-Adjustive Approach*, *Establishing Readiness for Counseling*, *The Initial Interview*, *The Exploratory Phase*, and *The Synthesis Interviews*.

The story of client James Walsh unfolds as we travel chapter by chapter, until in the end he finds satisfaction in self-realization and self-direction. The case illustrates excellently many of the points the authors make. The book ends with two chapters of a more general nature—*Evaluating Counseling Procedures* and *All Campus Applications*.

Laying the Foundations, Chapter 3, and *The Synthesis Interviews*, Chapter 8, are of special interest. They are practical, clearly illustrated, thorough for the space allotted the topics, and an excellent comparative review of the various schools of thought on counseling, especially the directive and the non-directive. The "Bibliotherapy Reference List," in Chapter 7, contributes an intriguing phrase and a list that arouses interest and speculation.

Counseling is defined by the writers as "an attempt by a counselor to create a permissive situation in which the client may reevaluate his experiences and so bring the self into closer harmony with experience." And "counseling can be said to be successful when the individual has reintegrated his self-concept to include goals more consistent with his aptitudes, interest and self-perception and the fundamental need for maintenance and enhancement of self has been satisfied and is accompanied by feelings of self-direction."

In this framework, the reiterative phrases are "self-adjustive," "client-centered" counseling, "the whole student," and "thinking with the client," not "for" or "about" him, so as to aid him in "becoming self-directive." Each chapter contributes to the why and how of this phraseology, and repeatedly emphasizes client responsibility in the counseling process. This is done clearly, practically, and convincingly. Problems and solutions are presented in such form as to make the material more functional.

The book is a veritable index to counseling and guidance literature. There is hardly a page that does not carry references to page and chapter in some other text. For me, the numerous references are distractingly numerous, but interesting as a fine review of the body of knowledge in this special field. The bibliography is excellent—varied and extensive.

Counseling is viewed, not as a separate program or entity, but as an integral part of the total educative process and educational program. And this is as it should be.

Although the text was written mainly for counselors in schools and colleges, its mental-hygiene approach and developmental presentation make it practical and understandable for all persons concerned with the "adjustive" process of human beings. It would be a useful, readable addition to the libraries of personnel managers, social workers, ministers, and all individuals who are engaged in counseling at various levels and situations.

The Dynamics of the Counseling Process lives up to its title and is dynamically presented.

ESTHER M. DIMCHEVSKY

University of Denver

RECOVERY FROM APHASIA. By Joseph M. Wepman. New York: The Ronald Press Company, 1951. 276 p.

This is an up-to-the-minute presentation, supported by years of research and clinical experience. The author is, at present, clinical instructor in otolaryngology (speech pathology) and lecturer in psychology at the University of Chicago. He defines aphasia as "any language problem resulting from organic disturbance of cortical tissue in which the defect is not due to faulty innervation of the musculature of speech, dysfunction of the peripheral sense organs, or general mental deficiency."

His concept of recovery involves not speech alone, but a total personality readjustment, a new-found stability as a person. He says:

"Recovery from the disorder of language, it is believed, is based upon over-all recovery of the individual with a new ability to function in society as a contributing part of that society. . . . Recovery of the ability to speak, to read, or to write while the patient is still unable to adjust to society is a futile and useless goal. Language skill in a person unable to resume a normal or satisfying place in society is a wasted resource. A resumption of social intercourse in a manner mutually acceptable to the patient and to society, a controlled reduction of the effects of the personality aberrations which follow brain injury, stability of the psyche, and insight into the physical limitations imposed by the brain insult seem to be the important goals. Language should be considered as the means of interpersonal relations, not the end result of recovery."

"It is a major thesis of the book that only a combined effort can hope to achieve the kind of results that are possible after brain injury." This "combined effort" involves the active coöperation of the speech pathologist specially trained in aphasia therapy, the physician, the nurse, occupational therapists, physiotherapists, and others of the hospital staff, while the brain-injured person is at the hospital, and after he returns home, the additional coöperation of his family.

The book is divided into three parts. Part I, *The Nature of Aphasia*, (42 pages), is a carefully documented summary of aphasia theory from Broca to the recent findings of Halstead, Lashley, Luria, Goldstein, and others. "While not overlooking the contribution of the 'localizationists,' the writer believes that a more hopeful prognosis can be made for aphasic adults with the acceptance of a non-localizationist viewpoint in accordance with which recovery follows reintegration of the remaining cortical tissues into a functioning whole." (Italics are the author's.) Because of the welter of overlapping categories and neologistic terms, the author presents his own classification designed to provide "a discursive description of language behavior" and "a basis for the beginning of therapy."

Part II, (pages 45-82), reviews the research findings during World War II. Major considerations are the effects of training, leading to conclusions with respect to the amenability of the aphasic patient to therapy. Of special interest to the therapist contemplating a program for aphasia training are data on the following topics: (1) the most effective time to begin training; (2) the relationship between measurable I.Q. and aphasia; and (3) the most effective way to use instructors in the program.

The remainder of the book comprises Part III, *Aphasia Therapy and Therapists*. Here the author presents his theories and working principles relating to the qualifications and training of the aphasia therapist, the preparation for professional aphasia therapy, the problems involved and the pitfalls to be avoided in the treatment of both receptive and expressive aphasia. The manifold problems and the author's suggestions for handling them are set forth in such detail, and with such clarity and understanding of their nature and the needs of the patient, that the reader is everywhere impressed with the authoritative nature of the work.

Recovery from Aphasia is a "must" for any one who would be well informed on the subject, as well as for the aphasia therapist—a term used by the author to include "every one concerned with the task of rehabilitating the aphasic patient."

FREDERICK W. BROWN

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FREUD OR JUNG. By Edward Glover. New York: W. W. Norton and Company, 1950. 207 p.

The recent revival of interest in Jungian psychology, spurred in part by the recognition by some psychotherapists of the participation of religious feelings in mental therapy, has been taken by Glover, a leader in British psychoanalysis, as a point of departure for an intimate analysis of this psychology. The emphasis by Jung on creativity as a function of self or ego, deriving its energy from a Universal or Collective Unconscious, acclaimed by those interested in aesthetics and its psychological explanation, has been a further stimulus to the author's analysis of Jung. Moreover, the inadmissible merging of Jungian and Freudian concepts in the minds of psychological laymen (especially in England) with resulting overtones of metapsychological mysticism, has goaded Glover into the work of analyzing the differences between the psychological systems of Freud and Jung, and of analyzing the latter himself.

The result of this comparative study has been to state more clearly than has been stated before the utter irreconcilability of the two systems. There is no issue between Freud and Jung, Glover states.

There is no means of "compromising between a theory based on unconscious psychology and one based on an exclusively conscious psychology" (p. 193). By divesting the unconscious of its dynamic significance, by avoiding the defensive and repressive functions of the unconscious ego, by eschewing the fact of infantile sexuality, by neglecting the evolution of the ego as an organization that adapts instinctual forces to reality under pressure of its environment, Jung has returned to a position of pre-Freudian psychology.

In a word, Glover finds the Jungian psychology to rest on a mystical, static basis, while psychoanalysis is derived from psychobiology. As the author puts it, "Jung's whole outline of the development of the individual substitutes for an evolutionary approach from unconscious to conscious . . . a closed system of interrelations, compensations, balances and antitheses" (p. 47). Glover examines the metapsychology of Jung, with its array of psychic institutions—"persona, anima, animus, shadow, archetypes, Personal Unconscious and Collective Unconscious"—and its accent on religiously toned psychic force which forms the central core of the self. He strives without success to match up the structural and dynamic equivalents of which Jung writes with those of Freudian metapsychology.

The mystical connotations of the Racial Unconscious are particularly hard for psychoanalysts to follow, as is the superior, condescending, pedagogic air of the Jungian analyst. Glover feels that Jung, in "anthropomorphizing the dynamic unconscious," with symbols deriving from the Germanic Racial Unconscious in part and from Oriental unconscious deposits, "proclaims himself a dynamic psychologist with a unique perception of the 'dark' and 'deep' forces that influence human affairs" (p. 46). The fact that Jung claims dreams have a "prospective" tendency—i.e., the capacity to foretell the future—and that he speaks of "individuation" as a coming to realize the "selfhood" or "new center of the personality, the point at which God's image shows itself most plainly," puts Jungian psychology, for Glover, outside the pale of scientific psychiatry.

As the author follows Jung into his own species of predestination on a psychologic level, into alchemy and Yoga on a philosophic level and into National Socialism (*circa* 1938) on a political-sociologic level, he is struck, as is the reader, by the amazing confusion of personal prejudices, anthropomorphic projections, and racial dramatizations that encumber Jung's psychology. Pointedly, Glover indicates Jung's one consistency of thought in his "unswerving determination to produce a system which shall negate the theories of Freud" and to prove the laws of the unconscious to be "inaccurate, totally false or totally unnecessary" (p. 86).

While Glover lays the Jungian ghost with incisiveness and dispatch,

he gives a running description of Freudian psychology in clear and masterful terms. Chapters on mental structure, mental energy, and mental mechanisms, constructed to offer a base line from which to measure and evaluate Jung's theories, are consummately written. Their force is derived in part through comparisons that the reader must make with Jung's "sliding-scale of meaning which baffles exactitude," as revealed in quoted passages. Perhaps also the gusto of Glover's exposition stems from the happy task he set himself—to prove that the "progress of Jung's theories ever since his defection from Freud has constituted a Grand Retreat to Conscious Psychology."

This task is performed with distinction and devotion.

But the larger task of keeping psychoanalysis clear of any temptation to desert psychobiologically derived postulates for religio-philosophical ones, is the greatest service Glover renders.

WALTER BROMBERG

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NOTES AND COMMENTS

ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The One Hundred and Ninth Annual Meeting of the American Psychiatric Association was held at the Statler Hotel, Los Angeles, California, May 4-8. It was attended by some 2,800 people, of whom 1,261 were members of the association.

The program as usual covered a wide range of topics, from the technical and clinical to those of more general interest. Among the latter might be mentioned international psychiatry, to which a special program and a dinner meeting were devoted; problems of the aging and of retirement; and military psychiatry, including an account of recent psychiatric procedures with the forces in Korea.

There were two movie symposia, one of them of a predominantly mental-hygiene nature, and a number of round-table meetings in addition to the regular scientific sessions.

The annual dinner meeting, held on May 6 was the occasion for the presentation of awards. The Hofheimer Award went this year to Dr. Thomas H. Holmes, Lester N. Hofheimer, Dr. H. S. Goodell, Dr. Stewart Wolf, and Dr. Harold G. Wolff, for their book, *An Experimental Study of Reactions Within the Nose in Human Subjects During Varying Life Experiences*.¹ The Isaac Ray Award was given to Dr. Gregory Zilboorg, for his professional contribution in the field of legal problems connected with mental disorders. The Mental Hospital Institute Awards were assigned as follows: first award to Selkirk Memorial Hospital, Manitoba, Canada, Dr. Edward Johnson, superintendent; second award, to Enid (Oklahoma) State School, Mrs. Anna T. Scruggs, superintendent; and third award, to the V.A. Neuropsychiatric Hospital at Sheridan, Wyoming, Dr. E. S. Post, manager. Three institutions received honorable mention: the Sonoma (California) State Home, Dr. M. E. Porter, superintendent; The Anna (Illinois) State Hospital, Dr. E. C. Steck, superintendent; and the Polk (Pennsylvania) State School, Dr. Gale H. Walker, superintendent.

Dr. Kenneth E. Appel, of Philadelphia, will serve as president of the American Psychiatric Association for the coming year. The president-elect is Dr. Arthur P. Noyes, of Norristown State Hospital, Norristown, Pennsylvania.

The 1954 meeting of the association will be held in St. Louis, Missouri, May 3-7.

¹ Published by Charles C. Thomas, Springfield, Illinois.

AMERICAN PSYCHIATRIC ASSOCIATION ESTABLISHES ENDOWMENT FUND FOR MENTAL-HEALTH PROJECTS

The American Psychiatric Association has established an endowment fund for the support of projects that will advance mental health, according to a recent announcement of Dr. Kenneth E. Appel, president of the association.

Gifts to the fund from interested citizens will be used to study the nature, causes, treatment, and prevention of mental disorders, to raise standards of treatment and care for the mentally ill in hospitals, to further psychiatric education and research, and to make psychiatric knowledge useful to other branches of medicine, to other sciences, and to the public welfare. Such gifts are tax exempt.

The association's governing council of four officers and twelve fellows elected by the members will administer the fund.

AMERICAN PSYCHOSOMATIC SOCIETY ELECTS OFFICERS

At the annual business meeting of the American Psychosomatic Society, held on April 18, 1953, the following persons were elected to office: George L. Engel, M.D., president; Lawrence S. Kubie, M.D., president-elect; and Theodore Lidz, M.D., secretary-treasurer.

THE NEW YORK NEUROPSYCHIATRIC CENTER

On April 6, 1953, the New York Neuropsychiatric Center, 312 East 15th Street, celebrated its third anniversary. It was established in 1950 by Dr. William D. Sherwood, professor and Chairman of the Department of Neurology and Psychiatry at Columbia Postgraduate Medical School and Hospital; Dr. Carl Fulton Sulzberger, chief of clinic; and Dr. John B. Scanlan, assistant attending psychiatrist.

To-day its staff comprises twenty psychiatrists, one psychologist and assistant, and two psychiatric social workers, with Dr. Sherwood as director, Dr. Sulzberger and Dr. Scanlan as clinical directors. Miss Norré C. O'Brien is administrator, Dr. Paul Rabinowich heads the department of psychology, and Miss Ruth M. McGuire and Miss Dorothy G. Simpson, the department of social service.

The center has given more than nine thousand psychiatric treatments, in addition to psychological tests, social-service interviews, diagnostic consultations, and neurological examinations. It now holds sessions one afternoon and three evenings a week to provide low- and medium-cost psychiatric treatment in accordance with the best medical standards. All therapy is given by psychiatrists only.

The center has never received any endowment or other funds, and is the only psychiatric clinic supported entirely by the patients' fees,

which start at \$6.50 and are based on ability to pay. It has become an important treatment resource to Greater New York, and plans expansion of its facilities and establishment of a training and research program for the fall of 1953.

WESTERN RESERVE ANNOUNCES A NEW GRADUATE SEQUENCE IN EARLY-CHILDHOOD EDUCATION

The establishment of a new graduate program for workers with young children has been announced at Western Reserve University, Cleveland, Ohio, effective with a summer session, which started June 22.

Coöperating in the presentation of the new program will be the faculties of the university's school of applied social sciences, the department of psychiatry of the school of medicine, and the division of education.

The three-semester program will lead to the degree of master of arts, with a concentration on early-childhood education. Students will take 36 semester hours of work, 28 hours of which must be in specified courses.

The content of the new program has been designed for students interested in three related types of work—(1) as teachers, directors, or supervisors of early-childhood-education centers, such as nursery schools, day-care centers, parent coöperatives, and private kindergartens; (2) as educational specialists with groups of children in residential settings and hospitals; and (3) as leaders in the field of parent education.

New courses in the sequence to be introduced at Western Reserve, starting with the fall semester, 1953-54, will include problems in early-childhood education; observation, participation, and field work; techniques of work with parents in groups; personality maladjustment and its symptoms in children; and supervision and administration of the nursery school and the day-care center.

Four existing courses in the division of education have been scheduled for the summer session, enabling students who enter the new program to begin at once.

Sharing responsibility for planning the new education sequence at Western Reserve have been Mrs. Emma K. Plank, assistant professor of child development in the department of psychiatry and assistant professor of education; Dr. Robert E. Mason, professor, and Dr. Clifford L. Bush, assistant professor, of the division of education; Miss Josleen Lockhart, assistant professor of social case-work at the school of applied social sciences; and Miss Eleanor M. Hosley, executive secretary of the Day Nursery Association in Cleveland. Mrs. Plank

will teach the special early-childhood-education courses being introduced into the education-division's curriculum.

Western Reserve's newest graduate program is being financed through a gift from one of the university's trustees, Howard E. Wise, who is contributing \$25,000 over a five-year period to establish the sequence.

AGENCIES UNITE TO COMBAT PENDING DELINQUENCY CRISIS IN AMERICA

Over 350 agencies working with delinquent youth have recently merged to form one strong national organization. The new organization is to be known as the National Association of Training Schools and Juvenile Agencies and is an amalgamation of The National Association of Training Schools and The National Conference of Juvenile Agencies. The strengthened leadership possible from one organization will enable the member agencies better to combat the increased case loads that will result during the next decade. Statistics of the U. S. Census Bureau and the U. S. Children's Bureau show an increase of children between the ages of ten and seventeen of at least 42 per cent by the year 1960, with no possibility of a reduction until at least 1971. This rise in births will have a definite effect on services for delinquent youth.

Mr. Raphael Farrell, Superintendent of the Boys Training School at Red Wing, Minnesota, was elected the first president of the newly formed national organization. Mr. Farrell referred to this combining of organizations as "timely and essential both in terms of leadership, improved services, and—more important—a bringing together of the 'minds' in the field to strengthen and clarify a basic philosophy of treatment and operations." Mr. Farrell further stated, "Juvenile delinquency is rapidly facing the crisis stage in America. Thirty-five thousand (35,000) youngsters are now in training schools for delinquents and every state is reporting continuous increases. Another 100,000 boys and girls under seventeen are served each year by agencies of this group other than the training schools. With the increased birth rates recorded at 42 per cent and the present teen-age population being recorded at approximately twenty million, it is urgent that we create a strong organization in an attempt to intelligently handle the obvious delinquency load of the future."

The following were elected vice-presidents of the new organization: Alfred Cohen, State Training School for Boys, Warwick, New York; Donald Coldren, State Training School for Boys, Topeka, Kansas; Miss Ann Moroney, State Training School for Girls, Cranston, R. I.; and G. Howland Shaw, nationally known civic leader from Washington, D. C. The secretary-treasurer is Wendell Fewell, Glen Mills,

Pennsylvania. Temporary headquarters for the organization will be located at Glen Mills School, Glen Mills, Pennsylvania.

FUNCTIONS AND QUALIFICATIONS OF PSYCHIATRIC NURSES

"What's wrong with psychiatric nursing?" "Would you say that you are doing any psychotherapy?" "What kind of support do you like and want in your work?" "Would you need more preparation to do the things the good psychiatric nurse ought to do?"

These are some of the questions that were asked of psychiatric nurses across the country in the gathering of data for *A Study of Desirable Functions and Qualifications for Psychiatric Nurses*, recently published by the National League for Nursing.

The study, which was conducted by Claire Mintzer Fagin, R.N., in coöperation with an advisory committee of psychiatric nurses and psychiatrists, lists seven general qualifications for psychiatric nurses:

1. Intelligence, attitudes, and motivations required by work in a psychiatric facility as determined by whatever established criteria are available.
2. An attitude of inquiry into the thoughts, feelings, and actions of one's self and others.
3. Trained capacity to make inferences and judgments.
4. Ability to express warmth for people and an appreciation of their difficulties.
5. Ability to be imaginative and resourceful in limited situations.
6. Good health and physical stamina.
7. Appreciation and understanding of the special knowledge needed in psychiatric nursing.

The activities of psychiatric nurses are listed under four functions:

1. Collecting significant data relating to identification of problems and steps toward their solution.
2. Making inferences or judgments based on such data.
3. Acting on the basis of such knowledge.
4. Evaluating the entire process.

The study contains a list of suggested activities for psychiatric nurses in the following positions: staff nurse, head nurse, psychiatric nursing specialist, supervisor, administrator, instructor, education director, and consultant. Desirable qualifications for each position are also given.

Several ways of bringing current practices in psychiatric nursing into closer harmony with the report's recommendations are suggested. These include discussion at state and local meetings, further research,

demonstration wards in state hospitals, more detailed study of the technical skills necessary for practice in psychiatric nursing, consideration of the problems of recruiting more nurses for psychiatric nursing, and clarification of the functions of the psychiatric nursing specialist and the consultant.

The need for such a study is indicated by the fact that half of the patients in the country's hospital beds are classified as psychiatric patients, while only 5 per cent of the nation's hospital nurses are employed in psychiatric facilities.

To supply information for the study, more than 200 psychiatric nurses from all over the country answered questionnaires and cooperated in interviews and conferences.

The study, financed through a grant from the National Institute of Mental Health, U. S. Public Health Service, was conducted under the Mental Health and Psychiatric Nursing Project of the National League of Nursing Education and the National Organization for Public Health Nursing, both of which are now a part of the National League for Nursing.

Copies of the 104-page mimeographed report may be ordered from the National League for Nursing, 2 Park Avenue, New York 16, N. Y. The price is \$1.50 a copy.

WARD ADOPTION PLAN AT ANNA STATE HOSPITAL

The Illinois Society for Mental Hygiene, quoting Dr. E. C. Steck, of the Anna (Illinois) State Hospital, reports that "the ward adoption plan is developing just fine. Sixteen clubs have adopted one or more wards. Their activities include the sending of birthday cards and the providing of parties, clothing, magazines, sweets, and tobacco treats for patients. Other clubs, not sponsoring special ward activities, have been sending subscriptions to magazines, books, and musical records. In addition, these groups participate in party planning for patients on convalescent wards."

THE HANDICAPPED WORKER CAN EARN HIS WAY IN INDUSTRY AND BUSINESS

The handicapped worker in American industry and business must be accepted on an equal basis with all other workers, Paul A. Strachan, President of the American Federation of the Physically Handicapped, said in a recent interview, in which he strongly opposed all social and economic disadvantages placed upon the nation's some 30,000,000 disabled people.

The handicapped have proved that they can perform a basic service

for industry and society by the very fact that they have received in excess of \$2,000,000 in wages and salaries in the last ten years. "American industry would not have paid out this huge sum in wages to the handicapped unless they were earning their own way," Mr. Strachan said.

"In the last hundred years, industry has spent billions of dollars on maintenance of equipment and buildings, but not until recently did they begin to think of people, and last of all they thought of the handicapped.

"The handicapped problem has been treated and regarded as a charity proposition. We have bitterly contested this attitude, working with leaders of the nation along this line. Our success in making inroads against a callous attitude toward the handicapped shows up in the following figures: since the American Federation of the Physically Handicapped was launched in 1942, more than 2,000,000 persons with some sort of physical infirmity have been placed in gainful employment through federal and state employment services.

"The public should stop talking about people in the sense of being blind, amputees, cerebral-palsy victims, or epileptics, and regard them as full-fledged citizens—as people of these United States who can and are willing to earn their own way.

"The job which confronts the American Federation of the Physically Handicapped is this—every possible effort must be made to integrate the handicapped into the national social and economic structure, not as disabled individuals, but as people. We must make the public understand that they have to accept them as people—and that we have to coöperate with them as neighbors, fellow workers, citizens, and friends.

"We must continue every possible means to afford the necessary medical treatment and education that will enable the handicapped to mingle with the public and to uphold their obligations and self-respect.

"One specific achievement of the federation was the enactment, on August 15, 1952, of the Omnibus Research Act, which provides funds for research in the fields of cerebral palsy, arthritis, poliomyelitis, epilepsy, muscular dystrophy, and other ailments, that contribute so largely to the ranks of the handicapped."

The American Federation of the Physically Handicapped, which Mr. Strachan organized in 1942 and whose destiny he, as president, has since guided, promotes the hiring of the handicapped. It is the initiator and sponsor of "National Employ The Physically Handicapped Week," enacted by Congress and now Public Law 176. The first full week in October of each year is set aside for a nation-wide campaign to promote employment of the handicapped.

The federation has a bill pending in Congress that will establish a federal agency for the handicapped, to handle various phases of this great and complex problem.

SUICIDE RATE AT RECORD LOW

(Reprinted from the *Statistical Bulletin* of the Metropolitan Life Insurance Company, May, 1953.)

The suicide rate among industrial policyholders of the Metropolitan Life Insurance Company established an all-time low last year. The rate for 1952—namely, 5.6 per 100,000 at ages 1 to 74 years—was 10 per cent less than that in 1951; the previous low of 6.3 per 100,000 was recorded in 1945. . . .

With the close of World War II, the suicide rate took an upward turn. The war-time motivations that usually lower the suicide rate were gone; many ex-servicemen experienced difficulties in readjusting to civilian life; and the tempo of industrial activity slackened. It was not possible to forecast then how long the suicide rate might continue upward or how high it would go. There was little comfort in looking back at the experience following World War I, because the upward trend in suicide which began in 1920 continued through the early 1930's. Fortunately, the pattern of the period after World War I has not been repeated in the experience since 1945. The fact that the suicide rate is now at a record low is a good index of the psychological and economic well-being of our people.

For each sex and in every age group, the recent suicide rates have been considerably below those of the period just prior to our entry into World War II. Thus, white male policyholders in 1950-1952 experienced an average annual rate 28 per cent below that for 1940-1941. The reduction was even larger for white females—namely 35 per cent. In fact, suicides among women declined more than among men in every age bracket, thus widening the difference in the rates between the sexes.

Men and women differ markedly in the relative frequency with which they use various means for self-destruction. During 1950-1952, about two-fifths of the white male suicides were by firearms, one-quarter by hanging, and one-fifth by taking some form of poison. None of the other means—such as jumping from high places, drowning, or the use of cutting or piercing instruments—was responsible for as much as 4 per cent of the total male suicides. Among women suicides, poisoning by solids, liquids, or gas was the leading means, accounting for almost two-fifths of the total. Slightly more than one-fifth of the women put an end to their lives by hanging and approximately one-sixth by shooting.

The prevention of self-destruction depends upon detecting the early signs of mental depression and persuading the potential suicide that his or her difficulties can be resolved constructively. More thought is being given by the medical profession to the recognition of such symptoms and the evaluation of the risk of suicide. The greatly increased provisions being made for economic security at the older ages through annuities and pension plans, life insurance, and individual savings should help to reduce suicide resulting from economic pressures in later life.

Even though the suicide rate is currently at a record low, it still accounts for about 17,000 deaths a year in the general population of the United States. In addition, large numbers of men and women attempt suicide unsuccessfully. The problem of preventing suicides is, therefore, clearly of major significance and merits greater attention than it has so far received.

PIERRE THE PELICAN NOW IN MOVIES

The Louisiana Department of Institutions, in the first of a new series of mental-health bulletins, reports that *Pierre the Pelican* is now in movies:

"Expectant Parents Meet Pierre the Pelican is the title of a new 16-mm sound movie recently completed by the Louisiana Society for Mental Health. The film, edited by Dr. Loyd Rowland, runs eleven minutes, and was designed especially for doctors, nurses, and other health personnel. Copies of the film can be purchased from the Louisiana Society for Mental Health, 816 Hibernia Building, New Orleans; price \$20.50.

"A study of the post-natal *Pierre* series of pamphlets recently was conducted by the Michigan Department of Mental Health, and the considered opinion of the researchers was that the series was effective. Sample findings:

"We may conclude that the *Pierre* parents had a more elaborate concept of child-rearing theory than did the control parents as measured by this method. According to these results, the "subjective effect on the recipients" of the *Pierre* letters was such that they gained some comprehension of the dynamics of child rearing theory."

"There is a strong indication that the *Pierre* parents have a better comprehension of the material involved in the concept questions and when considered in conjunction with the evidence found in the mail survey, we may conclude that the *Pierre* letters make a worth-while contribution to parents' understanding of child-rearing practices."

"Readers of the letters tend to give the same answers to the questionnaire even though they have differing backgrounds, while parents who have not read the letters tend to have more areas of disagreement according to their backgrounds."

NEW TYPE OF HANDBOOK FOR EMPLOYEES IN NEW YORK STATE'S
MENTAL HOSPITALS

Copies of *This Is Your Job*, a new booklet for employees in state hospitals and schools, have been distributed to the 28,000 persons employed in the 27 institutions maintained by the New York State Department of Mental Hygiene.

The 33-page colorfully designed book is the first of its kind prepared by the department, and represents an entirely new approach to employee relations. Friendly and informal in tone, it is not a book of rules and regulations, but an easy-to-read guide to institutional service. Written in a popular style, it is generously illustrated with eye-catching cartoons by Bob Gustafson, who draws the well-known comic strip, *Tillie the Toiler*.

"The purpose of the handbook," Dr. Newton Bigelow, Commissioner of Mental Hygiene, pointed out, "is to orient the employee, particularly the new employee, to the functions of the institution, the important rôle he will play, and what is expected of him. It attempts to prepare him for some of the problems he will encounter and to make him aware of the contribution he can make."

The new booklet will replace the former employee manuals and will be distributed to all present and future mental-hygiene department workers.

In a foreword to the book, welcoming both old and new employees to the department of mental hygiene, Dr. Bigelow states:

"If you're new, there are probably many things about working in a mental institution that are strange to you and difficult to understand. Even if you're an old hand at it, there may still be some things you'd like explained. In this booklet are the answers to the major questions."

Under the heading, *You're on the Team!*, the booklet points out that service in a state institution means enlistment "in a magnificent cause—the rebuilding of human lives. The institution exists for the care and treatment of patients whose lives have been upset, sometimes completely shattered, by serious mental disorders. Its aim is to restore as many of them as possible to their jobs, their homes, and families."

Whatever the particular duties assigned, the book further declares, the work of the employee is directly or indirectly concerned with the well-being of patients. These patients differ considerably from those in general hospitals because their illness shows itself in abnormal behavior instead of in the more familiar ways.

The major portion of the new book deals with patients and the ways employees may assist them to better mental health and shield them from injury or exploitation.

The necessary regulations governing institution employees, as well as the benefits and requirements connected with state jobs, are described briefly in the final chapters of the book.

A RESEARCH STUDY OF HOMOSEXUALITY

If homosexual patterns are to be avoided, methods of child-rearing, the question of coeducational training, and cultural attitudes toward early heterosexual activities should be scrutinized carefully, according to Dr. Karl M. Bowman, professor of psychiatry at the University of California's Medical School, and Mrs. Bernice Engle, research assistant in sexual deviation, in a pamphlet, *The Problem of Homosexuality*, recently issued by the American Social Hygiene Association. Investigators must study such problems as possible physical or hereditary abnormalities in sex organs and glands, as well as psychologic and social influences on the development of sexuality. The subject of sex hormones and their relation to other glandular secretions is complex and needs careful, extensive investigation.

Some observers argue that social factors and cultural attitudes in this country oppose the extension of heterosexuality and thus indirectly encourage the formation of homosexual ties. Many parents and educators, afraid that boys and girls will get into trouble if they see too much of each other or indulge in heavy petting, provide only limited opportunities for young people to make contacts with the opposite sex.

"Our knowledge of psychosexual development suggests that a father should take an important part in training his son and in restraining his instinctual drives, while the mother should offer warm care and affection. The boy thus has a man to identify with and a beloved mother-figure to possess as an ideal," the researchers point out. Boys and girls should have many opportunities to mix with each other and to form early attachments, but sexual interests should not be stimulated until adolescence has begun.

From the legal standpoint, any person convicted of carrying out a sexual act with a person of the same sex would be convicted of homosexual activity and classified as a homosexual. Some individuals so convicted may be completely homosexual in their attitude and behavior and have no interest whatever in heterosexuality. But other individuals convicted by the courts may not really have desired a homosexual experience, may have felt disgusted at having yielded to the approaches of the partner in the act, may have in the past led an active heterosexual life, and may lead an exclusively heterosexual life in the future.

The latent homosexual—who has never had overt homosexual experi-

ences—is ordinarily no legal or social problem, although his latent homosexuality may result in all sorts of neurotic behavior. This group includes those who consciously desire homosexual relationships, but carefully control these impulses in the same way that many persons who desire heterosexual relationships control the sexual drive.

A second group of latent homosexuals includes those who consciously have no interest in homosexual relations, even react with disgust to the idea, but who do have strong homosexual drives of which they are unconscious. Their behavior is often motivated by these drives operating in some disguised fashion, researchers point out.

Society is interested mainly in the overt homosexual who leads a fairly active homosexual life and who may be responsible for initiating others into homosexual activities, the Bowman-Engle report states.

Although never the predominant sexual activity in any society or animal species, homosexuality occurs to some extent among adults of almost all cultures so far studied, including those that ban it most severely. It is more common among males than among females both in human beings and in animals, especially the primates. In 49 primitive societies in which some type of homosexuality was considered normal, many tribes looked upon pre-adolescence as a time for experimentation in various sexual practices, heterosexual and homosexual.

Studies have shown that biologic components and factors of personality development apparently are so closely interrelated that a variety of mechanisms at different developmental stages may disturb the individual's attainment of sexual maturity, just as they may encourage left-handedness.

Psychologic views about homosexuality are varied. One that has attained fairly general acceptance is the idea that male homosexuality stems from a fixation during early childhood sexual development or a regression to infantile sexuality, and is aggravated if the boy has a weak father (or none) in his upbringing.

All observers agree that overt homosexuality is less common in women, is probably less intense, and meets with less social disapproval than in men. Dr. Bowman and Mrs. Engle recommend that an intensive study be made of the large group of male homosexuals of a particularly virile, masculine type who go in for active sports and become noted athletes.

They point out that the results of individual and group psychotherapy of homosexuals are discouraging. Many psychiatrists state that treatment does not influence the patient's homosexuality, but may help him make a better adjustment to it. Although cure is usually no longer possible, analytic treatment may perhaps bring harmony,

peace of mind, and full efficiency to the unhappy, neurotic patient, and sometimes it succeeds in "developing the blighted germs of heterosexual tendencies" present in every homosexual.

Many experienced psychiatrists believe that homosexuality is no offense unless young children or violence or public indecencies are involved. Implementation of this belief would mean the changing of laws about the culpability of adult homosexuals and their acts.

Laws regarding homosexuality vary even more than do medical and anthropologic views. In 46 states laws specify sodomy—usually defined as sexual intercourse between two males—as illegal. More general statutes in the other two states—New Hampshire and Vermont—outlaw sodomy.

A causal connection between homosexuality and criminality is not at all clear, in the opinion of researchers. They point out that homosexuals as a group are unhappy and discontented, but that most of them control their social conduct within the same legal bounds as do others.

As medical superintendent of San Francisco's Langley Porter Clinic, Dr. Bowman is conducting scientific research into the "causes and cures of sexual deviation, including deviations conducive to sex crimes against children, and the causes and cures of homosexuality, and into methods of identifying potential sex offenders." To find out whether there is any correlation between endocrine or other biochemical imbalances and emotional and mental factors, the California project is studying certain steroid sex hormones and anti-enzymes in the urine and blood of homosexuals committed to two state hospitals near Los Angeles.

AIMS OF ELEMENTARY EDUCATION REAPPRAISED

A new appraisal of what elementary education should seek to do is made in the report of the Mid-Century Committee on Outcomes in Elementary Education—a committee of thirty-two outstanding educators—recently released by the Russell Sage Foundation, which supported the two-year study in coöperation with the Educational Testing Service at Princeton, the United States Office of Education, and the Department of Elementary School Principals of the National Education Association.

"We know now," say the educators, "that we cannot set the same learning goals for all pupils and that we cannot be highly specific in assigning the development of knowledges, skills, and abilities to definite grade levels. We no longer believe that failure or the threat of failure causes pupils to work harder and achieve more, or that pupils who are required to repeat grades or courses gain very much

in the process. We do not believe that children are by nature stubborn and resistant to learning and that they must be forced to learn. We believe, instead, that children want to learn, try desperately to learn, and sometimes persist in their efforts to learn despite the most unfortunate and discouraging experiences."

The report, entitled *Elementary School Objectives*, sets goals of knowledge, skills, and attitudes for children at third-, sixth-, and ninth-grade levels both in precise subject fields such as geography and spelling and in broad areas such as social relations. It holds neither with "progressive" nor with traditional education. Says Dr. Nolan C. Kearney, who writes the report for the committee: "Elementary education, like a bride's trousseau, should have something old and something new. He who would start with drill and memory work will be helped to see many of the applications in the activities and experiences of children. He will be assisted in relating facts and skills to interests, to motives, and to needs. He will be reminded of the conditions that affect the behavior of children. On the other hand, he who would start with activities and experiences will be reminded of the various tool subjects and skills that children will need. He will be provided with suggestive outcomes against which to check the progress of children and through which to interest and motivate classes."

The recommendations of the Mid-Century Committee stress again and again the need for skills in writing, reading, and arithmetic and factual knowledge in geography, history, government, science, hygiene, and all other fundamentals. But they also emphasize the fact that children must themselves see and feel the need for finding out—for learning. The old-fashioned knowledges and skills are there, and the recommended goals are not objectives that only the brightest are meant to attain.

Education goals, says the report, must be set for each child in terms of his abilities, aptitudes, and talents. Some children exhibit one talent, some another. A child may be above some group average in reading or music, and below average in arithmetic and science. For instance, the reading ability of typical fourth-graders may vary as much as six years, and of typical sixth-graders by as much as eight years. This is true despite any effort to level them off by intensive drill, by high selection, by failure, or other means. The teacher must adapt his selection of outcomes to this pattern of individual and trait differences, judging whether they are of sufficient importance to the individual pupil or to society to have an acknowledged place in the regular school program.

The psychology of learning has developed to the point where it lays open to question many educational procedures that have been followed for the past century. "Common sense," Mr. Kearney points out, "is a great deluder and should be depended upon only when real evidence is not at hand. It was common sense that said that heavy objects fall faster than light objects, that people should always rest in bed following surgery, that bleeding reduced the ill effects of 'bad' blood, that the earth was flat, that there are only three dimensions, that light travels in a straight line, that matter is indestructible. There is no end to a list of the failures of common sense. In education, many people still believe that certain subjects 'sharpen' the mind, teach logical thinking, and so on. Many still believe that children learn to read best by first learning the alphabet and phonics. Others think that making children repeat grades and courses is an effective way to ensure high standards of learning and that a thing is 'learned' when it can be readily recited from memory. There is much evidence to refute or greatly to modify such beliefs."

For example, it has been demonstrated how much easier it is to remember verbal materials that are understood than to remember those not understood; that children first learn large undifferentiated ideas or concepts and later fill in the details, instead, as was formerly assumed, of learning the details first; that tremendous difficulties are involved in teaching such generalizations as the nature of justice, democracy, and friendliness, and that children must be properly motivated if they are to learn and remember. The result of these "new" ideas is a "new" child who learns from experience, from doing something.

The goals for elementary education, as this study shows them, indicate that two things are needed to enhance public faith in what the schools may be doing. One is for the public to become more familiar with the schools. The other is for the schools to have available better means to assess for themselves, and for the public, the results of the educational process. As Dr. Henry Chauncey points out, "The future of our way of life is peculiarly dependent upon what happens in our elementary schools in the next decade or two."

ANNOUNCEMENTS OF MEETINGS

The Annual Conference of the National Council on Family Relations, originally scheduled for September 1-3, will be held at the Kellogg Center for Continuing Education, East Lansing, Michigan, August 31-September 2. Further information may be obtained by writing to the National Council on Family Relations, 5757 So. Drexel Avenue, Chicago 37, Illinois.

The American Occupational Therapy Association has issued the preliminary program of its Thirty-sixth Annual Conference to be held at the Shamrock Hotel, Houston, Texas, November 13-20. The general theme of the conference will be "Refining Our Resources." An institute on "Research in Occupational Therapy" will precede the general program.

The Biennial Conference of the National Association for Nursery Education will be held in Minneapolis, October 28-31, 1953.

The program will include sections on administration of the nursery school; parents; research; legislation and standards for nursery schools; television; coöperative nursery schools; nursery schools for exceptional children; and nursery school in relation to later school experiences.

Among the speakers will be Dr. James L. Hymes, Jr., and "Miss Frances" of Ding Dong School. There will be a reception for all the authors of the publications of the National Association for Nursery Education.

The conference chairman is Dr. Elizabeth Fuller, Institute for Child Welfare, University of Minnesota, Minneapolis. Programs and registration blanks may be obtained from her.

The headquarters hotel is the Hotel Nicolette and reservations should be made directly with the hotel.

The International Association for Child Psychiatry announces a two-day international institute on "The Emotional Problems of Children under Six." This institute will be held in Toronto, Canada, on August 12-14, 1954, in connection with the Fifth International Congress on Mental Health. Attendance at the institute will be open to all professional workers dealing with the emotional problems of young children, including psychiatrists, psychologists, social workers, sociologists, pediatricians, other physicians, nurses, teachers, welfare workers, court personnel, governmental officials, and any others dealing with these problems.

The association invites clinical case studies of such children for presentation and intensive discussion by an international panel. Each case submitted for presentation will have the same basic preparation, beyond which each worker will be expected to carry out those studies which he himself finds desirable from his own scientific and cultural viewpoint. Cases presented may be either those that have been intensively treated or those that present interesting problems in the course of thorough diagnostic studies.

For full details write to Dr. A. Z. Barhash, Secretary-General, International Association for Child Psychiatry, 186 Clinton Avenue, Newark 5, N. J.

The association also invites descriptions of current research projects dealing with the main topic. Accounts of research into the psychiatric, biosocial, biochemical, or biophysical aspects of the mental functioning of children in the first five years of life are invited. Work in progress will be given equal consideration with that which has already produced definitive results.

For further information about research papers write to: Dr. Gerald Caplan (Assistant Secretary-General, I.A.C.P.), Harvard School of Public Health, 695 Huntington Avenue, Boston 15, Massachusetts.

RECENT PUBLICATIONS

A unique guide for social case-workers in helping foster children has been published by the State Committee on Children and Public Welfare of the State Charities Aid Association. The booklet, . . . *But I Always Like You*, is written in non-technical style and is an out-growth of a special program which the committee has been conducting in New York State for the past year and a half. This program, consisting of a series of meetings for foster parents, provides a medium for the discussion of problems frequently encountered in caring for children away from their own homes. Already there have been more than seventy such meetings arranged by local citizen groups in coöperation with public and private child-welfare agencies in New York State, and many other localities, in the state and elsewhere, are planning similar programs.

The title of the booklet was taken from a remark made by a foster mother who said at one of the meetings, "We have to help the child to understand that 'I do not always like what you do, but I always like you.' "

The booklet was prepared only after a clear demonstration that it would prove valuable to case-workers. It complements another booklet, *Step by Step*, published last year by the committee as a guide for community groups in planning and conducting foster-parent meetings.

The foster-parent program and the publication of the two guides have been financed by the Grant Foundation and the Doris Duke Foundation.

. . . *But I Always Like You* is available at 25 cents a copy from the State Charities Aid Association, 105 East 22nd Street, New York 10, New York.

Publication of the *Proceedings of the Second Research Conference on Psychosurgery* has been announced by the National Institute of Mental Health, Public Health Service, Federal Security Agency.

The Second Research Conference met in June, 1950, under the chairmanship of Dr. Fred Mettler, Columbia University, to discuss

the subject "Evaluation of Change in Patients After Psychosurgery." Edited by Dr. Winfred Overholser, the proceedings include design of rating scales for psychotic patients; base line data and psychiatric categories; evaluating the environmental situation of the mentally ill patient; analysis of schizophrenia; affectivity and psychosurgery; deterioration and regression; creativity in psychosurgery patients; and descriptive scales for rating currently discernible psychopathology.

The research conference group was established upon the recommendation of the National Advisory Mental Health Council and has been supported by grants from the National Institute of Mental Health. Three annual conferences have been held to exchange information and develop plans for research in lobotomy. The first conference, held in New York in 1949, discussed "Criteria for Selection of Psychotic Patients for Psychosurgery."¹ The final conference, which met in 1951, considered "Therapeutic Evaluations of Psychosurgery,"² and summarized the findings of the three conferences.

Single copies of the *Proceedings of the Second Research Conference* (Public Health Service Publication No. 156) are available free to professional personnel at the National Institute of Mental Health, Bethesda 14, Maryland.

A CORRECTION

In the article by Dr. Bryant M. Wedge, "Psychiatry's Aid to College Administration," in the April issue of MENTAL HYGIENE, two of the pages were transposed. Page 207 should be 208 and vice versa.

¹ *Proceedings of the First Research Conference on Psychosurgery.* Edited by Newton Bigelow. Public Health Service Publication No. 16. \$1.00 per copy.

² In press.

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ROBERT A. TAFT

IT is not the function of MENTAL HYGIENE to editorialize on general political issues. On the other hand, the advancement of mental hygiene is very dependent on governmental activities and, by corollary, on the principles under which government operates. Public health, public education, public psychiatry, and public welfare are essential to the advancement of mental health. Robert Taft was in general opposed to the enlargement of federal power and function, but it is significant that he saw the need for strengthening and broadening federal activities in the mental-health field as something of an exception. The problems of mental deviation, as he saw them, are so great and so expensive and so far beyond control by any one state or community that they call for federal action. This action may take the form of research, training, and aid to states. It was a sign of his integrity that he could make an exception where the conditions were exceptional. We had an opportunity to discuss this with him in 1946, when the National Mental Health Act was under consideration. It was he—even though he was not a sponsor of the legislation—who brought about a reconsideration of the bill in the Senate in order that its financial limit might be raised. We are glad to make this a matter of record, in tribute to Mr. Taft to be sure, but also to nail down a principle that is crucial to this field of mental health.

GEORGE S. STEVENSON

MENTAL HEALTH: A LOCAL PUBLIC- HEALTH RESPONSIBILITY*

HOWARD E. JENSEN

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I THINK we can look forward with confidence to a not-distant future when the responsibility of the local public-health department for the mental health of the community will no longer be discussed. "If it isn't mental health, it isn't public health," will have become the motto of every local public-health department in the country, so universally recognized in theory and realized in practice that its entire personnel—from telephone operator, receptionist, clerk, and typist, to nurse, technician, engineer, clinician, and administrator—will be thoroughly trained in the mental-health implications of his job.

In fact, we have already reached the point in the public-health movement where further advance in the protection and improvement of the physical health of the population is beginning to require a mental-health orientation. In any well-organized community, the public-health movement has done about all that can be done through its traditional procedures. It has removed the foci of infection in the physical environment through community sanitation, in the commercial distribution of food and beverages through inspection and control, and in the human organism through case-finding, immunization, and quarantine. It has greatly reduced the nutritional diseases through educational procedures resulting in changed food tastes and habits, in the use of more protective foods and balanced diets in the family, and in the development of a more balanced agriculture of food crops, vegetables, live stock, poultry, and dairying in the region. Through its programs for maternity and infancy hygiene, it has reduced the morbidity and mortality of mothers and children to a point but little above the minimum determined by

* Presented at the Annual Convention of the Georgia State Public Health Association, Savannah, Georgia, May 5, 1952.

the biological quality of the stock and the present state of medical science. And so on *ad infinitum*.

In all these traditional activities, the public-health movement has already reached the point of diminishing returns. Further progress will require the initiation and use of new procedures. Even improvement in physical health is coming to depend less upon changes in the geographical and biological environments than upon changes in what people think and feel and how they live within the social institutions and cultural patterns of the community. Thus, the physical health of the baby brought to the clinic often depends less upon the staff's competence in weighing, measuring, and adapting its food formula than upon their competence in giving its mother emotional reassurance in her own rôle as a mother. The venereal-disease patient has no more need for the penicillin treatment and prophylactic knowledge that he receives than for the maturer philosophy of life and scale of social values that make for better social adjustment in the future, which he too often does not receive. For with a maturer social adjustment, he will require no further penicillin or prophylaxis; without it, he may become a sullen and defiant repeater. The finest community facilities for the treatment of disease in general are of little avail unless the inner feeling states of the patient and his family, upon which acceptance of and response to treatment so largely depend, are sympathetically understood and skillfully adjusted.

And let us not forget the long arm of the nurse. She reaches out into the community with a range of interpersonal relationships that, for variety, quantity, and quality, no other member of the staff can equal. She sees people most casually and informally, when they are most natural and least defensive, in their homes or on the street, at work or at worship, at school or at play. No one is so strategically located as she to observe the effect of how people live with others in the community upon even their physical well-being, and to use this knowledge in helpful advisory or supportive ways.

The engineer, the sanitarian, or the inspector also requires a mental-health orientation to perform his duties at the top level of efficiency. His work is destructive of community values and hence of mental health to the extent to which he

relies upon his police powers to secure compliance with minimum standards of housing or sanitation. To the extent to which he knows how to motivate the citizen to conform in the common interest, he is not only working creatively in the field of social values and mental health; he is also generating a public opinion which will demand that the present legal minima be transcended.

The telephone operator, the receptionist, the clerk, the typist, even the janitor, require some knowledge of how interpersonal relations affect the well-being of people, and some skill in their management. The cheery voice, the ready smile, the helping hand, and the kindly attention that are neither forced nor feigned, but that spring spontaneously from a genuine liking for people and a sympathetic interest in their problems, have a profound effect upon the patient who telephones or who calls at the clinic, anxious about the present, guilty about the past, and worried about the future, or who is impatient at the seemingly interminable waiting for his turn. He is highly sensitive to the emotional atmosphere that surrounds him during these initial experiences; and his readiness to play an active rôle in his own treatment, and to make full use of the knowledge and skill offered, is largely conditioned by it.

Mental health, then, will be recognized as an inescapable responsibility by every local health department that has a modern dynamic conception of public health. It is indispensable to the full discharge of the task to which the public-health movement is historically committed. Most people are able to forge out of their discordant impulses and desires an approximate mental unity, stable enough to deal with the problems that arise in the normal processes of living. But probably in no one is the integration ever inclusive and complete. As the present air-force cases show, every one has his breaking point. Every critical situation that interrupts the normal course of a person's life is, therefore, to some degree potentially traumatic, in many cases excessively so. When such situations have a physical basis, the public-health department has an established reputation as the agency to which people turn for help. No other agency in the community has so frequent and enduring contacts with such people. None,

therefore, is in so strategic a position to deal with emotional disturbance in its incipient stage.

The act of turning to a public agency for help is symbolic of many hidden meanings of which the person is but dimly, if at all, aware. It may symbolize his incapacity to deal with his own problems, and, therefore, be deeply resented as a threat to his independence. It may represent a confession of guilt as to the real or imagined consequences of his past behavior, and be weighted with feelings of inferiority and humiliation. It may portend a frustration of his most cherished ambitions, and leave him burdened with anxiety. It may be attributed to the unmerited consequences of the behavior of others, or to the meaningless buffetings of fate, and engender a burning sense of outrage or injustice. It may have all of these meanings, and countless others that lie buried in the depths of the unconscious. The person cannot do otherwise than react to them with the latent tendencies already developed. He is sullen and rebellious, flippant and flirtatious, hostile and aggressive, uncooperative and resistant, dependent and irresponsible, anxious or indifferent, depending upon the style of life that represents his own unique integration of his past experiences.

The first obligation of the local public-health department in the field of mental health, then, is to perform efficiently the tasks to which it is already committed. It is already obligated to help those who seek its services to resume their places in the community as productive citizens. This requires a thorough assessment not only of the physical development and status of the individual, but also of the positive and negative factors in his subjective feelings and his objective social setting that have a bearing both on his physical and on his emotional recovery. To this end the routine clinical interrogation and laboratory tests are not enough. They can deal with the ostensible reason why the person seeks help, but the real reason often lies deeper. Its discovery calls for penetration beneath the superficial intellectual level of worker-client interaction to the deeper level of emotional participation. To this end the public-health worker must become a master of the fine art of listening, which encourages free and spontaneous self-expression through conversation. Talk-

ing is as essential to the soul shut up in its own emotions as breathing is to the body saturated with its own carbon dioxide. We have here much to learn from the lowly chiropractor, who is often more successful than the physician in treating cases with a large emotional component, not because his technique of relieving "vertebral subluxations" is correct, but because he has never been inculcated with formal professional attitudes, but maintains an informal, friendly atmosphere which enables the patient to find release from the inner emotional turmoil "that weighs upon the heart."

The restoration of the patient requires that he shall learn to think objectively about his problem and deal with it realistically, and the public-health worker cannot teach these things to his patient unless he is objective and realistic himself. But patients can be exasperating, and public-health workers are human, with their own emotional needs to consider. It is, therefore, inevitable that moments of exasperation should come, but when they do, the worker will recognize in them additional obstacles to treatment whose locus is within himself. He will realize that moralizing or jesting with the patient, or denouncing him to colleagues, may relieve his own emotional tension, but that they will do the patient no good, and that the primary responsibility for bringing mental-health concepts and techniques to bear upon the problems of those who need them most, rests with the public-health personnel. It is *not* their function to become psychiatrists and treat the definitely diagnosable mental illnesses that come to their attention. It is their function to do skillfully what their predecessors did more bunglingly, by recognizing the mental-health implications of the situations with which they are already dealing through a fuller understanding of what these situations mean emotionally and culturally to the individuals who are involved in them.

This mental-health orientation of the public-health department's personnel I should call the first line of defense for a community mental-health program.

This degree of responsibility for mental health will, I suppose, be accepted by every competent health officer in the country. But he has now to face a larger responsibility. Unless mental-health principles are incorporated throughout

the social structure of the local community, they are powerless to achieve their goal. Unless the emotional troubles are treated, the treatment is incomplete, and unless the social situation is treated, the emotional troubles cannot be fully resolved. For apart from any definite neuropathology in the individual, good mental health is largely a product of good human relations. The importance for mental health of the various social groups to which a person belongs are direct functions of the amount of time he devotes to them, and the dynamic character of what he experiences within them. For the growing child, the institutions that account for almost all his time are four in number—the home, the school, the playground, and the church. What he experiences within them affects him so dynamically, so profoundly, as to all but seal his destiny. For the adult, we must add the time spent and the experiences encountered on the job. It is true of all mankind that their mental health, their characters and personalities, their ideals and ambitions, the vim and zest, the persistency and courage, the sense of individual and social responsibility with which they face life as spouses, parents, neighbors, workers and citizens—in short, their capacity for love and service and their worthiness to be loved and served—are but indicators of the kind of men and women they have become through what they have experienced, suffered, and enjoyed in the family, the school, the playground, the church, and the workshop.

The public-health department cannot, of course, accept responsibility for the management of all that. It must, however, arouse interest, stimulate to action, and be ready with advice and leadership in all matters relating to mental health within the community. The key to the situation is a sound program of mental-health education. This implies more than spreading accurate information about mental-health principles by the most approved methods of mass appeal. For in no field are the methods of mass appeal so limited. The snob appeal, so effective in commercial advertising, cannot be used. Mental health cannot be sold to the public as a means of keeping up with the Joneses, of identifying with Hollywood's latest anatomic bomb, of becoming a man of distinction, or of making the breath kissing-sweet. Unfortunately, too, in

no field is the outcome of mass appeal so difficult to predict, for in no field are people so inclined to interpret the leaflets, radio transcriptions, dramatizations, and other sophisticated materials of mass education in terms of the very anxieties they were designed to allay. Care must be exercised lest by mass methods we unwittingly create such mass hysteria as only an equally mass administration of Mebaral can control. Even the simple factual statement that one out of ten will at some time be under treatment for mental disturbance may frighten people into giving money to establish a clinic, and at the same time create more mental disturbance than the clinic can cure.

Mass methods must of course be employed, but even when used with discrimination and insight, they produce only superficial effects. For life habits are not changed by information alone. The only effective education is that which influences attitudes and leads to action, and this cannot be done constructively on a mass basis. Mental-health education can here profit from the experience of the safety movement, which has learned that success depends less on transmitting information to the masses who need protection than upon selecting and motivating the few "index persons," or key people, who are in strategic positions to protect them. It does little good, for example, to inform aged people that their bones knit slowly and that they should, therefore, avoid unlighted, rickety stairways. But motivating householders to make stairways safe, or, better, motivating contractors to build living quarters for the aged without any stairways at all, pays handsome dividends.

Mental-health education that gets down to the grass roots will, therefore, be aimed at the "index persons" operative within the five basic community institutions already mentioned as crucial for mental health—the parents in the family; the administrators and teachers in the schools; the group social workers on the playground; the pastors, assistants, and lay leaders in the church; and the managers, superintendents, and foremen on the job. Genuine education consists in motivating people to want accurate knowledge, and to make rational use of it. To this end, the mental-health educator must understand the motivations and behavior patterns of the "index people" he is approaching, for only as he knows

what people want and how they get it can he motivate them to want something better and to get it more efficiently.

What, then, do these "index people" want, and how do they get it? Fortunately, the institutional relationships that are most dynamically important in mental health—that is, those of the family—are also the simplest. If we may accept it on Biblical authority that even evil parents desire good gifts for their children, can we not find scientific methods of making them want better gifts and of getting them more certainly?

Mental-health education is a continuing process that begins with birth and ends only with death. The times when it is most needed, and hence most readily accepted, are at certain critical turning points in life's journey—the young couple contemplating marriage; the young parents expecting their first baby; the infant confronted with his first problems of feeding, weaning, toilet training, erogenous-zone avoidance, sibling rivalry, and social adjustment to his elders and his peers; the young child facing his first sharp break with the all-protective home, unless it has been softened by previous experience with nursery and kindergarten; the adolescent whose physiological disturbances are made all the more tumultuous by confrontation with the four crucial life problems concerning which our educational system as yet has offered little help—(1) a philosophy of life ("What can I believe?"), (2) a moral code ("What is my duty?"), (3) the selection of a mate ("Whom shall I marry?"), and (4) the choice of a vocation ("What job shall I choose?"); the middle-aged couple confronted with loneliness as their children leave the parental roof; and the senescent who must adjust his mode of life to conserve his dwindling powers.

In addition to these regularly recurring crises in the physiological life cycle, there are the unpredictable casual breakdowns, bereavements, estrangements, periods of unemployment, reversals of fortune, physical disabilities. It is these critical periods of life, when desire is most intense and obstacles most frustrating, that provide the greatest hazards to mental health, but also the greatest opportunities for the deepening of insight, and the teaching and application of mental-health principles.

It is in these family situations, especially in connection with

prenatal, maternal, and infancy services, that public-health departments have made their most promising beginning toward integrating mental-health programs into the institutional economy of the local community. The approach to the school, the playground, the church, and industry has been more hesitant, because these institutions possess a trained professional or experienced administrative personnel of their own. Educational leaders are conscious of the enormous loss of educational values due to emotional disturbance, and are aware that no school system can hope to discharge its educational obligation to its child population without special classes for emotionally disturbed children and competently staffed departments of psychiatrically trained social workers in the schools. Churches also have begun to provide clinical training for theological students, and institutes through which experienced clergymen and lay workers can acquire experience with the newer counseling techniques. Recreational leaders are rapidly awakening to the fact that their traditional programs of leisure-time activities are largely negative, and that the newer social group-work techniques contain vast possibilities for a constructive contribution to personality and character training that is still largely in the future.

Industrial leaders have been more slow to recognize their vital stake in the mental health of the worker. Men trained largely in economics and technology find it difficult to realize the enormous waste due to emotional disturbance as a major factor in accident-proneness, absenteeism, labor turnover, and reduced man-hour productivity. Yet the proportion of workers suffering from emotional stress is variously estimated at between 20 per cent and 40 per cent. These are the persons who, Gilverson believes, "by their faulty attitudes and clashes . . . cause most of the misery in industry."

But here also there are encouraging beginnings. British experience with personnel work in building morale in the army so impressed her industrialists that after the war they took most of the officers and enlisted men who had participated in the program and set them to work training foremen for similar service in their plants, with amazing results in improved worker-management relationships. And in America Henry Ford is but one of many who are calling for an industrial-

relations program under the direction of a professionally trained staff, competent to bring to the problems of human relationships "the same technical skill and determination that the engineer brings to mechanical problems."

But in addition to these "index persons" who determine the quality of the community's institutional life, there remain the professions whose sole function is to deal with crisis situations in the lives of those who seek their aid, the physicians and social workers in all their variety of specialties. Unless they, too, are integrated into the mental-health program there remains a serious break in its first line of defense.

What has the public-health department to offer to this array of "index persons" in the community's institutional economy? It can work with them through individual contacts and through educational materials adapted especially to their needs to increase their awareness of the value of mental-health concepts and techniques in achieving the ends they are already seeking to attain. It can work within their professional organizations by adapting to these purposes the group-discussion methods that are already proving so successful with young people preparing for marriage, with expectant mothers and even fathers, in nutrition work, and in other fields.

It can also apply these methods to inter-professional groups. It can serve as a coördinating agency for mental-health programs already in process, in somewhat the same way as it is already doing in the field of health agencies. It can stimulate and encourage experimental efforts on the part of other agencies. It can serve as a clearing-house for new ideas in the field of mental health and as a center for their dissemination.

Not all of these methods will be equally effective in all communities or with all groups, but a beginning can be made by experimenting with those that seem locally most acceptable to the groups most ready to participate.

This organization of the "index people" in the community's structure, I should call the second line of defense for mental health.

No doubt many public-health officers will interject at this point, "If this is what is meant by mental-health work, we have been doing it for years, and never knew it!" For it is an unfortunate accident of history that the term "mental

hygiene" has come to have in the public mind a quite different connotation from its corresponding term, "physical hygiene." The latter has never meant anything else than that branch of medical science which relates to the preservation and improvement of physical health. But because of the deplorable state of the mentally ill a century and a quarter ago, the pioneers of the mental-hygiene movement, from Dorothea Dix to Clifford Beers, focused public attention so exclusively on the need for mental hospitals and the improvement of hospital care that the meaning of the term has to most people become a synonym for hospital, clinical, and private treatment of mental patients.

Last week I asked a class of forty-five Duke University sophomores to write for me their conception of what mental hygiene is, and what is included in a mental-hygiene program. Only seven stressed the management of the emotional aspects of human relationships which we have thus far discussed. Perhaps a considerable proportion of the present public-health personnel also understands a community mental-health program to mean a system of hospitals and clinics, and intensive case-finding services to discover patients who need this type of care. However that may be, it is certain that a headline in the local newspaper reading, "Health Department to Conduct Mental-Hygiene Program," will all but universally be understood to mean that they are going to open a clinic.

A clinic, then, is the community's third line of defense for mental health. Instead of being the foundation of a mental-health program, it is the capstone. A sound community mental-health program is not built around a clinic; rather, it provides the setting for a clinic. No program can succeed that presupposes community conditions that are nonexistent. It would be as futile to try to operate a mental clinic without a preparatory orientation of the public-health personnel and a prior community organization of its "index people" as it would be to operate a venereal-disease clinic and leave untouched the foci of infection that precipitate new cases faster than the clinic can treat them. Nevertheless, if the community is large enough to support it, the time comes when, in the interest of further progress, you have got to have a clinic.

But a mental-health clinic that deals only with the final product of bad human relations is not performing its full

function. In the clinic, treatment is not an end, but a means. It is a means to helping the patient, to be sure; but more fundamentally, it is a means to further the orientation, organization, and education of the community in mental health through actual demonstration. When the citizen brings the patient to the clinic, he discovers that its chief reliance is upon objective, skillful listening, encouragement, and support on the part of the therapist; upon full confession followed by emotional release and growing insight on the part of the patient; and upon the development of the personal relationship of transference which enables the patient to find security in dependence upon his therapist. He discovers to his surprise that these are but scientific refinements on the crude methods that successful parents, teachers and pastors, and wise friends have been using ever since the human race began. That horrendous term, "psychotherapy," begins to lose its awe-inspiring mystery, and he becomes willing to accept responsibility for doing more systematically and skillfully what as a member of the community he has necessarily been doing haphazardly and bunglingly all along.

Though not wholly accurate, there is profound truth in the recent statement that "the principles of sound treatment in the field of mental health turn out, beneath the technical jargon of science in which they have been clothed, to be the simple, common-sense concepts of the Sermon on the Mount and the Golden Rule."

The building of these three lines of defense for the mental health of the community—the orientation of the staff, the organization of the community, and the operation of a clinic designed primarily to use treatment as a means of helping the community the better to help itself—present the local health department with a definite, practical, but arduous task. It promises no miracles. It has taken the public-health movement over a century to achieve its present status in the field of physical well-being. How long it will take to achieve similar results in mental health is in the laps of the gods. But one thing is certain: We must not enter upon the task too lightly or promise too much. We must not arouse expectations that we cannot satisfy. We must not oversell our program beyond our capacity to deliver within reasonable time limits.

It has taken a long time to overcome the fears and taboos

that people have with regard to physical weakness and contagious disease. It will take still longer to overcome the fears and taboos with regard to mental illnesses. For the public senses that the latter are due to far more personal reasons. They involve one's whole style of life, one's inmost self. And until public attitudes can be changed to accept the determinative rôle of external and unconscious forces in character and personality as well as in organic states, inability to manage one's own social relationships and emotional reactions will be a hard acknowledgment to make.

There is, of course, the objection that this program savors of "socialized medicine"—that the proper field of public health is prevention and that treatment should be left to private practice. But there is no such hard-and-fast distinction between the former and the latter. In the field of physical health, preventive work has in fact enormously increased the demand for medical services. Physical health cannot be protected and promoted without case-finding. Cases of contagious disease, cardiac lesions, skeletal, muscular, glandular, sensory and other defects both in children and in adults are referred for correction to the family physician or to the local clinic or hospital. The health education that results has helped to dispel the popular fallacy that one is well if one has no positive disease or infirmity. It has encouraged periodic diagnosis and early treatment. It has multiplied the demand for private practice. It has helped the physician to reduce what he fears most as a threat to his professional reputation—a high mortality rate. It has thus created conditions of medical practice that are less anxiety-provoking and more rewarding to the practitioner both as a physician and as a man. The activity of public-health agencies in the field of infant and maternity hygiene, for example, has practically driven the midwife from the field, has helped to increase the percentage of births attended by physicians in hospitals from 36 to over 90 since 1935, and thus to bring about conditions under which medical practice has been able to make mass application of the recent rapid advances in medicine and surgery and to reduce the maternal mortality rate by over 60 per cent and the infant mortality rate by nearly 50 per cent in less than two decades.

This will be true in even greater measure in the field of psy-

chiatry. One of the most discouraging features of this branch of practice is that it is so frequently possible to do little for the patient because the psychiatrist can do nothing at all to change the institutional economy within which that patient must live.

But probably the greatest obstacle to the assumption by the local public-health department of responsibility for the mental health of the community is a large measure of insecurity on the part of health officers themselves. They are accustomed to move cautiously into new fields until they can feel the firm support of experimental science beneath their feet. They have been loath to undertake a program until four basic requirements have been met. First, the condition to be attacked must be one for which a definite etiology has been established. Second, a standardized technique of dealing with it must be available. Third, its ability to give general if not complete protection must have been demonstrated. Fourth, it must be capable of being multiplied indefinitely at low unit cost. The control of filth-, insect-, and rodent-borne diseases through sanitation in its widest sense; of food- and water-borne diseases through continuous inspection; of contagions and infections through case-finding, immunization, and quarantine; of nutritional deficiencies through balanced diets; of the morbidity of maternity and infancy through early and continuing supervision—in fact, the whole public-health program, until a couple of decades ago, was very largely based on these requirements. More recently, however, the increasing importance of the non-infectious diseases and of the degenerative changes of aging have required programs that conform to them less closely. Still, these problems remain within the physically observable, the tangible, and the ponderable. Criteria of normality can be established; deviant cases can be found; the amount of deviation can be measured, and the degree of improvement or deterioration evaluated.

But in the field of mental health we must work with intangibles and imponderables. The etiological factors in mental disease cannot be isolated by the techniques of the physical, chemical, and biological sciences. Nor can we immunize against them. For apart from a few organic psychoses and inherited neuropathic conditions, man suffers mental ill

health because he is a desiring, valuing animal. He lives not only for the physical satisfactions of his animal nature, which are specifically located in the needs of his bodily tissues; he lives also for values that exist nowhere outside of the cultural world which is exclusively the product of his own social existence, past and present—for a quality of life, for truth, goodness, beauty, holiness. He is a seeker of values, and frets when forces that he cannot control thwart their realization. He is a conserver of values, and frets still more when such forces threaten their destruction. In the attainment of values he knows good, and in their loss, evil, bereavement, insecurity, anxiety, shame, guilt. He is mentally healthy if in such circumstances he has the inner strength to find life still intelligible and supportable. He is mentally ill if, in his weakness, it breaks down into chaos and meaninglessness.

Because of the diversity of his values and his strengths, what is a traumatic experience to one leaves another unscathed, and because the greatest of all his needs is acceptance by his fellows, what happens to him matters less than the emotional atmosphere in which it happens. "Better is a dinner of herbs where love is, than a stalled ox and hatred therewith." If a child is secure in the love of his parents, it matters little when he is weaned or toilet-trained, or by what means he is disciplined. And as the Great War demonstrated, men can endure long hours, deprivation, fatigue, danger, and death, and still be capable of great accomplishments, if they can feel that they are sharing in a common enterprise to preserve significant values under leaders they can admire and trust, and whose reciprocal respect for them as men justifies the continuance of their sacrifice.

Fortunately, the psychological and social sciences have much to suggest as to how such an emotional atmosphere can be maintained throughout the institutional structure of the community, but they have nothing to offer in the form of quantitatively exact laws of nature. To health officers trained to the precision of the laboratory experiment, such a course may seem venturesome; but the human need is urgent; the challenge is great; and only as public-health workers have the faith and courage to pursue it can they ease the mental anguish of mankind.

PROGRESSIVE INDUSTRY AND THE WORRIED EMPLOYEE*

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INROADS into conventional patterns of thinking are made against the odds of resistance, fear, and, on occasions, open hostility. Occupational medicine, in its growth, has experienced an unusual duality of resistance—i.e., in the extramural acceptance of the specialty by fellow practitioners, and in its own intramural medical recognition of the relationship of worker needs to worker output.

Prior to the beginnings of World War II, medicine in industry was founded, in the majority of instances, on the patchwork-quilt concept of therapy—one “patched up” the mistakes of industry, using unproved and perhaps shoddy techniques, and avoided too extensive an effort at prevention. When case-finding methods began to be developed on a mass scale during the conflict of the forties, physicians in industry began to rechart their thinking away from therapy exclusively into the channels of preventive medicine.

A natural step in maturation, then, was the integration into the industrial-health program of the holistic concept of medicine. Consideration of the worker as a multi-lived individual, with interests in work, at home, at play, in church, and in the community—as a person with physical, emotional, social, spiritual, economic, cultural, and even ethnic components in his living pattern—has become the *modus operandi* in the progressive and respected health service of contemporary industry.

To-day's Employment.—The struggle in Korea, superimposed on the unsettled economy of reconversion, has demanded production levels of our plants that can be met only through the efforts of people. Even with all the technologic

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advances that have been made by our physical scientists, our plants, our laboratories, and our utility organizations must be manned by people; and it is this single commodity that is becoming scarce in the production triad of men, material, and machines. With the man-power siphonage by the Selective Service System an accepted loss factor, industry has had to turn to the marginal employee for factory staffing. This includes the older worker, the woman worker, the physically limited, and the emotionally impaired. Previously, iron-bound physical standards precluded our hiring any but those fit for combat duty with the Marines. To-day, the maintenance of such standards is economically unsound, and the realistic industrialist is taking on the handicapped, the aged, the distaff worker, and the neurotically ill.

An Unusual Industry.—In the foreground of current production activities is atomic energy, whose quiet entry into the family of big industries has been heralded less than its more newsworthy mushroom clouds over the wastes of Nevada and the Pacific Islands. Representative of the creative establishments in this field is the Oak Ridge National Laboratory, which, with its 3,200 employees, has been growing these past ten years in the ridge country of East Tennessee. Engaged in fundamental research, the production of radioisotopes, the design of new nuclear reactors, the solution of the problem of flight by nuclear propulsion, and the training of atomic engineers and scientists, this laboratory has employed a personnel of as wide a variety of physical and emotional structures as could be found in any melting pot of peoples. To staff this organization, a multitude of professions, crafts, and skills is needed. With physicists, chemists, metallurgists, and engineers in to-day's rare categories, none can be rejected for employment who can make a contribution. The objective, then, in an employment program, is to effect an intelligent and studied job placement, so that the individual in his new work environment will be able to tolerate such stresses as may appear on the job.

The concept of stress as "the wide variety of circumstances that render adaptation difficult or which call forth increased effort on the part of the organism," and the thinking of "any factor as stressful which acts in such a way as to disturb a state of physical, physiological, or psychological equilibrium

in the subject,"¹ have served as the springboard from which all placement activities are initiated.

Pre-Placement Studies.—It is the function of the health division to determine whether a candidate for employment is physically and emotionally qualified for the specific job for which he is applying. This is accomplished through a complex physical examination,² and an estimate of the personality structuring. As a basic step, each applicant completes a printed Cornell Medical Index Health Questionnaire,³ which contains, among its 195 questions, 50 items relating to suggestive neurotic or psychotic behavior forms.

This device, not in any way diagnostic, serves merely as an exploratory instrument. It gives one an immediate acquaintance with certain behavior characteristics of the individual and, further, it permits an early "foot in the door," so that after discussing the positively checked items in the somatic range, the psychological questions can be approached and discussed with ease. Each applicant completes this, but on technical personnel (college graduates in the sciences) a psychological examination,⁴ including an interview, several projective techniques, and a vocational or personal-interest inventory, is conducted to predetermine the individual's tolerance of some of the potential stresses on the job: work deadlines, high radiation work levels, explorations of uncharted research areas, failures in experimental efforts, report preparation, overdemanding supervision, displacement from home, housing shortages, a different cultural milieu, weather extremes, and so on. Added to the battery is an interview by a clinical psychologist, and finally, when indicated, the examining physician and the interviewer meet with the medical director to review the findings.

From this conference will come a decision to employ the

¹ See *Introduction to Psychotherapy*, by L. I. O'Kelly. New York: Prentice-Hall, Inc., 1949. p. 27.

² Including organ assessment, complete blood count, urinalysis, serodiagnostic test for syphilis, electrocardiogram, ballistocardiogram, audiogram, vision test with stereoscopic instrument, and Roentgen study of the chest (and the spine in more physically demanding jobs).

³ Published by the Cornell University Medical College and distributed by the New York Hospital, New York City.

⁴ Including the Rorschach psychodiagnostic technique, the Bender visual-motor-gestalt test, draw-a-person test, the thematic apperception test, the Kuder vocational inventory, and the Kuder personal inventory.

person unconditionally, or to employ him with the knowledge that his psychological deficit¹ is great, that constant emotional monitoring of the job will be necessary, that with concomitant therapy he will be able to function well, or that a further discussion with the research-division director concerned will be necessary to decide if sufficient environmental manipulation on the job can be effected to render the neurosis-beset candidate a contributing member of the laboratory's work society.

When such a person as the latter is employed, the only factor noted on the report of his physical examination is the one restriction of some 25 which is checked, and which reads: "No work involving great nervous tension." Nebulous though this statement is, laboratory experience has proved it to be a sufficient flagging to the supervisor that here is an individual who can function in the usual situation, but who is not the one to be selected for a task that demands high emotional output.

One final procedure undertaken before job placement is a second interview, when indicated, with a consultant psychiatrist (or clinical psychologist) who is familiar with the laboratory's demand on human resources, and who will attempt appraisal of the applicant's ability to meet these demands.

The one set of data conspicuously missing from the occupational-medical literature is that on the psychological requirements of jobs. On the physical and environmental demands, we have information aplenty. Lacking, however, are analyses of the stress elements and the personality factors best adapted to meeting those elements.

In order to establish a framework in which skilled placement of the professional employee might work, a special study of 40 of our physical scientists of Ph.D. level was undertaken.² In this study an effort was made to learn the characteristics possessed by a successful "producing" research person. Test findings were correlated with worth ratings, made by directors of the two divisions concerned (physics and

¹ See "Psychological Deficit as a Function of Stress and Constitution," by G. R. Pascal. *Journal of Personality*, Vol. 20, pp. 175-87, December, 1951.

² This study was conducted under the direction of Gerald R. Pascal, Ph.D., professor in clinical psychology, University of Tennessee, and Director of the University of Tennessee Psychological Services Center, Knoxville, Tennessee.

chemistry) and the laboratory's research director. Early conclusions point to a direct relationship between stability and productivity. Yet, because of the frequency of findings that in any other sample would bespeak deviation, one must re-tailor one's usual criteria, and not exclude from research activity the neurotically ill. Were one to do so, perhaps many truths would remain locked and undiscovered in the research laboratory.

Currently, a group of 80 students of the Oak Ridge School of Reactor Technology and a group of 40 visiting architectural engineers are undergoing testing and interview, so that eventually data will be available which, when applied, will aid in predicting the ones most likely to be successful in the research environment.

Orientation.—The emphasis on studying and knowing the employee as a "whole man," is made known to the laboratory personnel in many ways. At the end of each week, an orientation program¹ is held for all new workers employed during that period. The medical director or the associate medical director, in his visual-aid-abetted 45-minute presentation, discusses the reasons for the complete physical examination and outlines the services available in the health division. A portion of this talk covers the relationship of emotions to physiologic response, of interpersonal relations to job success, and the correlation of "worry" and somatic equivalents. The psychological orientation of the dispensary staff is passed on to the new group, so that it will be no surprise to them during a dispensary visit if they learn that on many occasions illness can be and is a form of behavior.

Other educational efforts are found in the laboratory's weekly newspaper, a four-page science-society-softball-safety saga, which carries a column on health—health in its broadest sense of total well-being. A listing of a few of the headline titles of this column will convey the spirit of this constant get-acquainted-with-mental-health approach: *Child Responds to Gentle Care, The Thing Called "Mental Health," Public*

¹ See "Orienting the New Employee in the Services of the Health Department," by J. S. Felton (*Industrial Medicine*, Vol. 16, pp. 519-25, November, 1947), and "Orientation of the New Employee by the Health Division of an Atomic Energy Research Laboratory—A Four-Year Review," also by J. S. Felton (*Industrial Medicine and Surgery*, Vol. 21, pp. 107-10, March, 1952).

Affairs Pamphlet Provides Practical Advice on Mental Illness, To-day's Physician Needs Knowledge of Human Nature and "Emotional Disease," and Early Environment Helps Mold Mental Health of Individual.

In talks to groups of employees—a division, a department, or a craft—the subject of accident-proneness is reviewed, backed by local anonymous examples. The counseling program of the health division is discussed, and even when material is offered on radiation protection, time is taken to discuss the reasons for the observance of existing regulations, and the dynamics involved in disobeying them.

In groups led by the associate medical director for weight reduction, reasons for overeating are developed through informal discussion among the group members. Such pamphlets as the following are ever available in our waiting-room racks: *Toward Mental Health*, *Mental Health is 1, 2, 3*, *How is Your Mental Health?*, *Scorecard for Parents*, *If Your Child is Slow*, *When Children Ask About Sex*, and *Eating Problems of Children*. Exhibits and their matching posters, fabricated at the laboratory, as in one case, told the story of "The Triangle of Worry"—the interconnections between mind and job, mind and peptic ulcer, and peptic ulcer and job.

Program in Mental Health.—Knowing of the efforts of the health division to improve the stress tolerance of the employee, supervision coöperates and refers to the health division individuals who present problems in work adjustment. Most gratifying to us, however, is the so-called self-propelled employee-patient who, recognizing that he is problem laden, comes in spontaneously, seeking help. Most productive in problem identification is the behavior-oriented staff of the health division. Insurance reports are scanned, and those bearing the private physician's diagnoses of peptic ulcer, migraine, "run down condition," or "exhaustion," are set aside, so that interviews with the employee can be held on his return to work after a period of absence for illness.

The dispensary-visit recidivist who is constantly injuring himself, or presenting a chronic headache, or suffering from repeated weekends lost to alcoholism, or displaying any physical evidence of an underlying psychogenically created disorder, becomes known to eye-sharp industrial nurses, who

identify the true need for specialized investigation and care, and refer the worker to a staff physician. Particular thanks are owing to the swing-shift and night-shift nurses who, in their multi-hatted rôles of mother-figure, confessor, "psychologist," adviser, healer of wounds, and helper for all problems, recognize a psyche that needs retouching.

Fairly frequently motion pictures on mental health are shown, ostensibly to the health division, but special guests are invited—special in the sense that they are those in need of psychotherapeutic help, and the picture may motivate them into securing that help.

The group talks stimulate certain of the employees into asking for assistance. A most amusing incident took place a few months ago. A chemical technician stopped me on one of the laboratory streets and asked, "Doc, do you remember the talk you gave to the chemistry division?" I recalled a meeting six years ago in 1946. "Well," he went on, "I've been thinking it over, and I've decided to come in and see you about a problem I have."

On occasion employees who have met with success through therapy have referred friends in for care. In keeping with what is being experienced in all physicians' offices, patients will bring in clippings which they have culled from the slicks or the newsprint sheets which exclaim the latest in medical findings. Many of these refer to psychosomatic medicine, and allow the employee to ask if his condition might have a psycho-genetic element as a causal factor.

The Problems.—These, then, have been the sources from which cases have come. What are the specific problems encountered in an industry in which the health service is watching the personnel with a keen appreciation of the rôle of emotions in occupational behavior? So far as the serious disturbances are concerned, there are the depressed employees who need immediate psychiatric assistance and who are referred promptly for hospitalization. A rare schizophrenia is seen, most frequently as a recurrence of an old service-connected upheaval. The anxiety states are encountered, and, at lengthy intervals, the uncommon involutional or paranoid patient is found.

For these, there is prompt identification and reference for

help, and for some of the latter, specific security measures are taken to preclude a premature return to the job. Of greater interest and importance, though, to the research effort, are the more subtle personality changes, the less well-defined symptomatologies, and the somatic manifestations clung to so desperately by the employee who is reluctant to admit that his disease may be psychogenic in origin.

A research physicist finds that he is unable to concentrate on his work, and on doing a preliminary literature search, discovers that he reads and rereads a single line of a document, absorbing none of its content. Interviews reveal a seething domestic situation, beyond the ability of the patient to handle.

A brilliant engineer responsible for new developments in design work prohibits vacations for his group—many of whom, after round-the-year, six-and-seven-day work weeks, almost need sabbatical leaves, let alone the regular two-week vacation. As he drives himself, so he drives his men—and then wonders why a mass neurosis appears.

A chemist offers the complaint that he knowingly alienates every one, and that he hears himself saying things that are derogatory and friend-repelling, but is unable to turn off these insulting verbal freshets.

A carpenter with a moderate-to-severe sense of religiosity becomes preoccupied over his errant son, fails to keep a thumb away from the revolving blades of a jointer, and loses a phalanx; while a cafeteria attendant who for years has been preparing salads one day quite thoroughly slices a finger. Why? Worry over a son scheduled for Korea.

A summer visiting professor, embroiled in the intra-departmental politics of academic life, comes to the dispensary for a sedative and presents a duodenal ulcer, hypertension, obesity, and hay fever. He accepts the etiologic explanations and utilizes his laboratory visit for some effective brief therapy.

A research scientist comes in too often because of recurrent headaches, and investigation reveals an ambitious wife pushing him constantly "to get ahead," which means thrusting him into administrative posts, away from his first love, the laboratory.

The ill effects of these behavior patterns are seen in an increase in absenteeism, turnover, injuries, rest periods, and dispensary visits; a lowered production; a too heavy reliance on supervision; an impaired efficiency; and needless additions to the rumor factory. Apprehensions appear that need new and better methods of communication to allay. Further hurt to the industrial society is felt, for all—the supervisor, the fellow employee, the supervised—must protect themselves, as Kubie has put it, from the neurotic process brought to work by the aberrant personality. It is this impairment of interpersonal relations that spells slowing of the research effort, and action directed toward preventive emotional maintenance is more than worth the effort.

The Solution.—Currently, the philosophy held by the medical director is that every physician in industry should be sufficiently familiar with deviant patterns of behavior and their correction to be able (1) to recognize a condition irrespective of its guise; (2) to orient the employee-patient in understanding the cause and effect sequence; and (3) to outline the therapeutic expectancy. His task is not to remove himself from a discomforting situation merely by saying, "You've got a headache. You better see the nerve doctor." It is his assigned function to explain, clarify, discuss, and review the condition with the patient, so that he will be motivated into wanting help and accepting the specialist under his true title.

Once accepted, what is the path taken? A consulting psychiatrist or a visiting psychologist will see the referred employee, with the purpose of determining whether the patient (1) needs frequent reassurance, which can be given by staff physician; or (2) can benefit by office or out-patient psychotherapy; or (3) needs to be institutionalized. Without giving any therapy on the job, one or the other of the consultants will discuss the situation with the referring physician, and local environmental manipulation will be undertaken, or the sources of specialized care will be made known to the patient, and frequent checks of progress will be made after he has been referred.

In this brief review, an attempt has been made at painting the mental-health program at a research laboratory. It is

only through a constant appraisal of an individual's ability to withstand stress and a guidance toward tolerance improvement "that man can function to his maximum capacity as a conscious, intelligent, rational, free human being."¹

To apply this program to the current productive scene, we believe that, based on the evidence at hand in this laboratory, all who have a relationship with industry—the private physician, the psychiatrist, the employment officer, the medical director—should know that, with adequate medical surveillance and understanding by line supervision, the "nervous" employee can pull his load. He is needed vitally in to-day's struggle for international homeostasis, and should be given every opportunity to serve as a functioning contributor to the world's defense goods, and leave each day with a feeling that his work has been a satisfying experience.

To reunite man, industry, and psychiatry, I would like to close with Dr. Donald Stewart's definition of our field:

"Occupational health is that aspect of medical practice concerned, among other things, with achieving harmony between the capacities of any individual and the demands of his occupation. Inevitably it must take heed of qualities of mind and temperament as well as organic health; and from that point it spreads to embrace group reactions and attitudes and the consequences of these to the individual, to the worker group, and even to society at large."²

¹ Dr. John Romano, in a speech on "Education for Professional Responsibility."

² From "Psychiatry as Applied to Occupational Health," by Donald Stewart. *The Lancet*, Vol. 254, pp. 737-40, May 15, 1948.

ASPECTS OF MENTAL HEALTH IN TEACHING AND LEARNING*

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WE meet at a time when the world is full of strife, confusion, distrust, and fear. To describe the present condition of man, I like to borrow Julian Huxley's eloquence:

"Our thinking is chaotic, our nerves are jumpy, we are prey to pessimism and depression, we seem frightened of our human selves. Our half of the world lacks a common faith; the other half has had imposed upon it a crude dogmatic faith which can never satisfy free men. Above all, we have lost our sense of continuity, our long-term hope, and seem only able to concentrate on prospects of immediate disaster or immediate methods of escaping from it."¹

The educator has to view his work from a different position: in his effort to bring up children, he extends his influence into the future, and only there will he be rewarded in his expectation of having contributed significantly to the formation of mature adults who are less susceptible to the disorganizing influence of fright and flight. After many years of disillusionment, we have come to realize that the accumulation of knowledge and the advances in technology—in short, the conquest of nature itself—have not automatically created a world that harbors happier people.

The latest science to come to fruition is the science of man himself. Not until our lifetime did the working of man's inner life become transparent. The potentials of the creative and destructive powers that lie in all of us, the conditions of life that lead best to man's most mature achievements—namely, his humanity—and, further, the intelligible and orderly progression of personality and character development—all these insights have filled our libraries during the first half of this century. It has become clear that since we conquered our

* Address delivered at the Mid-Year Faculty Conference on Mental Health, Grambling College, Grambling, Louisiana, January 19, 1953.

¹ See "Knowledge, Morality, and Destiny," by Julian Huxley. *Psychiatry*, Vol. 14, pp. 129-51, May, 1951.

natural environment, the sole disturber of our peaceful and creative pursuits is man himself. It has become apparent that our deepest suffering, our immense waste of human energies, are inflicted on man by man himself.

It is this awareness of the refractory effect of man's state of mind that found expression in the preamble to the charter of U.N.E.S.C.O. Its opening sentence reads: "Since wars are made in the minds of men, it is in the minds of men that peace will be established."

It is only good common sense to turn to the resources that the science of inner man has to offer and apply them to the bringing up of children. I should like to remind you that nothing has been more impressive, in all the voluminous research into the origins of attitudes and goals of man, than the repeated confirmation that these attitudes and goals are formed and anchored in childhood. A significant part of childhood's destiny lies in the hands of its teachers, and rests on the influence that they can bring to bear on the meaningfulness of school experiences, on good family life, and on sound community living.

We have come face to face with the fact that the 27 million children now in our elementary and secondary schools are poorly prepared indeed for adult life if we do not make their personality development the pivotal point on which to concentrate our efforts. Knowledge can be applied fruitfully and with social responsibility only when it operates in a human mind that is free from distorted emotions. This fact is demonstrated again and again in our guidance clinics and mental hospitals. We have to ask ourselves most searchingly: What are the essential needs of children in their formative years and how can we, as teachers, bring our influence to bear on the development of healthy personalities? We are asking, in effect, the question: What is mental hygiene?

To this question, I like to give the following answer: Mental hygiene concerns itself with all those influences on the individual which make the orderly unfolding of human capacities possible. This unfolding follows a natural sequence of maturational stages, physically and emotionally, and leads ultimately to a way of life that is fruitful to the individual and in harmony with the values of the group to which he belongs.

These values are man-made and vary in different societies. Our own democratic credo makes two attitudes the foundation of our spiritual existence—namely, respect for the individual and his dignity, and the responsibility that every one individually assumes for his actions. This formulation, as you can see, leaves room for the responsible dissenter or the responsible nonconformist. Mental health is, consequently, not synonymous with conformity.

The rest of my talk I want to devote to material more directly related to the educative process and the principles of mental health—in essence, to the interaction of the two. By way of introduction, I must say a few words about a basic problem—namely, the place of constitution or heredity in our present-day thinking about personality. Up to the turn of the century—and many people still are at that point—constitutional factors dominated our approach to personality development. It was generally believed that each individual possesses in his genes a set of hereditary characteristics that will determine the physical and mental dimensions of its bearer—in fact, that the destiny of the individual was fixed by his genetic pattern or his genotype.

Within the last twenty-five years a revolutionary change has taken place which has almost reversed the picture. Observations and research have revealed the incredible impressionability of the child in relation to his environment, for good or for ill. For example, children of feeble-minded parents, when reared in good foster homes, showed a most remarkable development in intelligence as compared to the children of a control group who continued to live with their feeble-minded parents. Since we are in a better position to control the environment than we are to control the genes, these new findings promised to open up boundless horizons on the educational frontier. Overoptimism developed, and parents as well as teachers felt that it was in their hands to mold children into whatever they believed to be most desirable.

Research in the last ten years has struck a sobering note and brought constitutional factors back into our thinking, but with a different emphasis. The whole question has become more complex; the controversy of constitution versus environment, of nature versus nurture, has become an argument with

false premises, because the two components interact and constitute reciprocal agents. We have come to see that certain patterns in the child—such as activity patterns, perceptual sensitivity, tempo and rhythms in bodily functions such as sleep, movements, eating, digestion, and so on—are constitutionally fixed and show a high degree of stability over the years. A very active child born into a family of more placid parents is constantly expected to behave in a fashion for which he is constitutionally ill equipped. In fact, such a child can develop nervous symptoms as a result of restraining his motility beyond tolerance from its natural flow.

It is of particular interest for teachers to apply these considerations to the problem of intelligence. Intelligence, once considered to be fixed by heredity, has been shown to be influenced decisively by environment, within, however, individual limitations. While on the one hand we have come to realize that every child has educable intellectual capacities, the degree of educability shows individual differences that are beyond our power to alter. Studies have shown that the I.Q. can be raised by stimulating experiences in childhood and particularly by emotional factors usually summarized as motivation. Attendance at nursery school, with enriching experiences in toys, play space, social contact, language, and perceptual stimulation, tends to supplement the limited stimulation that prevails in many children's families. This point of view has been given recognition in the report of the Midecentury Whitehouse Conference on Children with these words: "It was, therefore, concluded that the intellectual differences between high and low economic groups are explainable on the basic of the limitations or advantages in education and other important conditions of life that necessarily accompany these groups."¹

In assessing children's intellectual functioning, the teacher, then, has to differentiate between constitutional capacity, environmental deficiencies, and emotional interferences. Should these three dimensions of intellectual functioning be clarified by observation over a period of time—possibly by testing also—then the teacher is in a position to base her expectations

¹ See *Personality in the Making*, edited by H. L. Witmer and B. Kotinsky. New York: Harper and Brothers, 1952. p. 46.

of a child's learning as to rate and level on the solid basis of differential findings. This will enable her to bring to best fruition the latent capacities that the child possesses. If teaching can be done without too drastically overtaxing or undertaxing the child's potential, a permanent contribution to his mental health has been made.

I want now to become more specific in my discussion of mental health and the educative process. In order to accomplish this, I asked myself: What are the mental conditions that best help man to maintain a feeling of well-being, to behave in a socially useful way, and to withstand the unavoidable vicissitudes of life? From my experiences with children, adolescents, and adults, I have abstracted four conditions that seem to me to embody what we refer to as mental health. I will trace the genesis of these conditions and will attempt to uncover the ingredients of experience that, through the years of childhood, have cumulatively led to a mental state conducive to a way of life useful to others and to oneself.

The first condition I want to discuss with you can be summarized as the Sense of Personal Worth. This refers to a subjective conviction that it does matter in the world how I act, that my existence is of significance and value, that I am, so to say, entrusted with myself, to take good care of this trust, to protect its dignity, to cherish its hopes, and to assuage its yearnings. You realize already from the way I have phrased the description that the sense of personal worth is the indelible imprint in the self that is made by the significant relationships of childhood. This sense of personal worth goes always parallel with a trusting attitude toward life, a confidence in possible fulfillment and betterment. In contrast, the absence of the sense of personal worth leaves the growing child with a perpetual distrust, pessimism, and cynicism. Such a person will find any retaliatory and exploitative behavior, with its contempt for human dignity, irresistible. Such propensities eventually lead to character distortions, which make the individual an easy prey to illness, criminality, or ideological fanaticism. All these results are destructive either of the self or of others or of both. These grave consequences warrant careful scrutiny of the problem.

• The child's concept of himself is the result of the attitudes

that the significant persons of his life have had toward him. Acceptance and belongingness have in a real sense their origin at the mother's breast. This early beginning, however, is followed up by other influences, among which those of the teacher are of great significance. Unstable or shaky self-esteem is in large part traceable to the unstable and shifting attitude that adults have toward children. Children please the adult when they live up to expectation, and they are rejected when they disappoint their elders. This shift in the attitude of the teacher, whose own security is greatly enhanced by the conforming child, becomes indelibly manifest in the child's low self-esteem, in the shifting pattern of loving and hating himself.

A reasonable degree of stable relationship between teacher and child is essential for the maintenance of self-respect, without which a child cannot develop normally. Destructive practices and attitudes of teachers that creep easily—even if only in miniature editions or in latent phantasies—into the daily classroom life are those of shaming and belittling, distrusting and humiliating. These practices destroy the budding self-esteem in the child and lay the foundation for a self low in self-esteem and consequently low in the regard of others. The child who has the confidence that he can count on his teacher can also constructively accept criticism and blame from her.

I remember a ten-year-old boy, Freddie, who was brought up by his grandparents after his own parents had been divorced during his first year of life. One day his mother came to visit him after years of absence. The child told the principal that his mother had arrived, and that she had invited him to see her early in the afternoon. The principal asked Freddie whether he had completed his work, and Freddie answered truthfully that he had. The principal then asked the child to get a note from each of his teachers to confirm this. The child pleaded with the principal, saying that he would be late for the visit with his mother. The principal, interested only in the school routine, overlooked the rising anxiety in the child and told Freddie that he had to do as told.

The principal's distrust and disregard for the child's feel-

ings so infuriated Freddie that he ran out of the school building to meet his mother. While passing through the entrance door he made a vow never to set foot in this school again. In fact, he never did. This story needs no commentary; it speaks for itself and high-lights the point I have tried to make.

We come now to the second condition of mental well-being—namely, the Capacity to Distinguish between Internal and External Events, Between Feelings and Facts. This capacity enhances our ability to think rationally, to judge justly, and to act realistically. The division between our feeling life and the world outside is vaguer in most of us than we like to think. Phantasies merge with perception of the outside world and place our thinking easily on shaky ground. Thinking under such conditions is far from realistic. Only when we can clearly see which sensations arise within ourselves and which have external sources are we in a position to think realistically. This mental state carries a feeling-tone that can be described as a sense of mastery and sureness in response, a compactness as to the feeling of self, and a sure orientation in the ocean of physical and emotional events that engulfs us. Psychologists describe this condition in terms of ego boundaries. This concept, in fact, has become a cornerstone of the normal personality.

As you can see, the condition that I am describing here is closely related to the cognitive processes and is, therefore, of particular concern to teachers. The cognitive capacity to perceive correctly inner and outer events passes through several stages until it reaches its full development. The ability to think is not only useful in enabling us to add up our grocery bill correctly, but it represents a faculty that strengthens the division of self and outside, a division that does not exist in the young child. You are all familiar with the child's confusion of his own feelings with that of others, of blaming the mother for his pain and kicking the chair into which he bumped accidentally. Children, when angry, feel the other person is angry and act on that premise. Needless to say, such action has a high degree of self-reference; it is inappropriate and disrupts the communication between the individual and the people around him. It is surprising to see similar processes, however more subtle and devious, operat-

ing in older children and adults to the detriment of their personality integration.

To give a concrete example, let us take an every-day situation. We are all familiar with the fact that children—more than is usually realized—attach fears and phantasies to their school life and to the teacher in particular. These apprehensions in children—related to fears of failure, of inability to understand, of punishment, of parental disappointment, of competitive-aggressive behavior, or physical injury, and so on—these apprehensions in children can be used for conforming and controlling purposes by the teacher. This, however, results in phantasy elaborations that blend with reality. A loose grasp of reality represents always a serious threat to mental health. What can be done?

The fact that children experience emotions in relation to learning and school life should be recognized and made part of the learning experience. In order to prevent unhealthy elaboration in children, their active participation in classroom life, their free expression of feelings, and their opportunity for creative activity are basic requirements of sound teaching. The more real as a person the teacher can be in her relationship to the children she teaches, the more clearly they can see her, experience her, and test their opinions about her. Under these conditions the teacher ceases to be the target for the projection of children's phantasies. It follows that their grasp on reality will be more firm and, consequently, that they will be more interested in learning and more objective in relation to subject matter. This, needless to say, is the state in which learning can take place best and most successfully.

The third condition that deserves our attention is the Capacity to Tolerate a Modicum of Tension. You know that the threshold of tension tolerance in the young child is very low and that an uprising urge is not quieted until gratified. The postponement of gratification and the substitution of primitive gratifications by socially valued activities is education's main endeavor.

Let me explain: It is quite normal for the one-year-old, when the sensation of hunger makes itself felt, to become absorbed by the wish for food. In the ten-year-old, we expect that slight hunger sensations will not absorb all his attention

and render him unable to pay any further attention to the task at hand. We can expect that the knowledge that lunch time will come at the regular hour makes possible a suppression of disturbing and distracting sensations.

The same thing, of course, is true of all the inner urges and affects that continuously arise within us and threaten to disrupt our orderly activities. Some of these urges and affects—such as, for example, aggression—cannot find direct, uninhibited expression; they need a modified, socially acceptable outlet, usually called sublimation, as in organized games, in dramatic productions, in mastery of skills, and in the solving of problems. I might remind you that we speak of “tackling a problem” and “putting our teeth” into a difficult task.

What I am saying here is simply that the child has to experience anxiety in order to develop devices to master it. It becomes a question of dosage and timing. This runs counter to what you might have heard over many years—namely, that anxiety is an unhealthy affect and should be avoided at all cost. Is it not a distortion of the realities of life when we pretend to children that there is nothing to be afraid of? “We have nothing to fear but fear itself,” as F. D. R. once said! One fear that cannot be wholly eradicated is the fear of our inner conflicting desires.

In the effort to spare children the unpleasant feeling of anxiety, educators recommended self-expression as the safest road to emotional security. It was assumed that, with a maximum of gratification, the child would grow automatically into an individual not burdened by repressions. This has proved not to be true because the disintegrating interference of tension against which the child had not developed workable defenses left him weak and unstable. Conflict is part of life; to permit the child to experience conflict and, with the help of the teacher, arrive at a satisfactory solution, is part of the teacher's task. It is a most delicate balance that the teacher must maintain between the child's self-expression and adult direction, between giving immediate gratification and imposing postponement or suppression. As teachers, we should not be afraid of creating conflicts in children as long as they remain within the child's capacity to master productively.

One such experience of a fourth-grader I should like to tell you. Mike loved to read. His teacher was pleased by the boy's enthusiasm and whenever he wanted to go to the library, he got permission. What the teacher did not notice was the fact that Mike always was overcome by the urge to read when time for arithmetic came around. The teacher in the fifth grade realized that Mike had not the vaguest idea of the multiplication table. Since Mike was a bright boy, she gave him an ultimatum: either you know your tables by Christmas or you go back to the fourth grade. What did Mike do in this conflict? He learned his tables.

As a postscript to this story, I might add that Mike became an extremely able student of mathematics in high school and college.

I cannot leave this point without letting John Dewey speak. He warned the educator many years ago "that the proponents of freedom are in a false position as well as the would-be masters and dictators. There is a present tendency in so-called advanced schools of educational thought to say, in effect, let us surround pupils with certain materials, tools, appliances, etc., and let pupils respond to these things according to their own desires. Above all let us not suggest any end or plan to the students; let us not suggest to them what they shall do, for that is unwarranted trespass upon their sacred intellectual individuality since the essence of such individuality is to set up ends and aims. Now such a method is really stupid. For it attempts the impossible, which is always stupid; and it misconceives the conditions of independent thinking. There are a multitude of ways of reacting to surrounding conditions, and without some guidance from experience these reactions are sure to be casual, sporadic, and ultimately fatiguing, accompanied by nervous strain."¹ Let us not forget John Dewey's admonishment that the teacher, even in the most modern conception, has a place as an active and directive adult in the child's life.

A fourth condition of man that is identical with mental well-being is Self-Realization in an Accepted Rôle. By this I mean the feeling of identity that a person possesses, which

¹ "Individuality and Freedom," by John Dewey, in *Intelligence in the Modern World*. New York: The Modern Library, 1939. pp. 623-4.

is to say "the awareness of the fact that there is a self-sameness and continuity to the ego's synthesizing method and that these methods are effective in safeguarding the sameness and continuity of one's meaning for others."¹

This sense of identity takes shape in adolescence, but preparatory steps precede its definite achievement. As educators, we must ask ourselves whether we are preparing children to use what they learn in the positions that they will assume in society. This does not imply that an adjustment to the *status quo* is to be favored, but rather that the recognition of social facts as they are is basic for intelligent action. Lucid awareness of one's social position is not identical with passive acceptance of it. It has, for example, contributed immensely to the feeling of frustration in women that they were in large numbers exposed to the stimulating experiences of college education and later were in no position to apply their learning in any socially useful rôle, but rather had to content themselves with the status satisfaction that they owed to their degree. Obviously, the remedy is not to stop educating women, but to make them aware of the problem that the highly educated woman in this society is bound to meet.

We have to see to it that a curriculum is related to the realities of the life of the children for whom this curriculum is devised. Otherwise, school and life lie far apart, and ideals of achievement are allowed to flourish in children's minds which outside the classroom are contradicted by the social organization to which they belong.

The discrepancy between individual aspirations and the restrictions and taboos of society can result only in frustration and resentment. The school—especially in the case of minority groups—has to acquaint children with the social realities of their caste and class and assist them in developing clear-cut attitudes, awareness, and behavioral techniques to cope with these. Only from a clear understanding of the social realities in which a person finds himself can a course of action develop that will bring about social change. Democratic institutions, which inherently favor the process of social

¹ See "Ego Development and Historical Change," by Erik H. Erikson, in *The Psychoanalytic Study of The Child*. New York: International Universities Press, 1946. p. 363.

evolution, can be used rationally only by individuals who are acquainted with the operation of such institutions.

These are processes that children can learn in the classroom in solving the difficulties of their own miniature societies, and this experience will lead later to a clearer recognition of the social rôle potential with which the adolescent can identify himself. If the adolescent can do this realistically, without a feeling of failure, without self-deprecation or self-blame, then we have achieved our educational purpose.

The teacher cannot do this alone; society has to do its share also and adjust its organization to protect the self-development and the dignity of all its members. Social progress takes place through the wider distribution of knowledge, understanding, and awareness of individuals, which in turn forces social institutions to adapt themselves to these changing conditions.

You will be relieved to hear that the teacher is not expected to work miracles. Nevertheless, in thinking back over what I have said, the task of the teacher seems gigantic. It stands to reason that the teacher's task is a difficult one. Therefore, the training for the teaching profession or the selection of prospective teachers is of the utmost importance in terms of the mental well-being of children.

It has often been asked what the motives are, why people choose to become teachers. Do they love children, or do they love long vacations, or perhaps the status that goes with the profession and the fairly secure position? I venture to say that only a person who is genuinely interested in children can exert a formative influence on a child that will outlast in significance most of the subject matter it has learned in school. Just remember for a moment the teachers you had when you were a child. We have all had a teacher who has made an unforgettable impression on us.

At this point I like to sound a note of caution. Having a good relationship to children does not blow away all the teacher's troubles; indeed it creates new ones. It is a known fact that children easily ignore the teacher who has no meaning for them and that they involve a beloved teacher in all the personal and intimate conflicts of their young lives. To illustrate, let me tell you the story of Jack and his teacher.

Jack was twelve years old and his teacher, who had him for the second year in her class, had always got along splendidly with this often willful and impulsive lad. They were on good terms and it seemed nothing could happen that they could not straighten out. No wonder that Miss Jones was not overly alarmed when Jack started trouble. He got into the habit of disturbing the class, of interrupting, of falling from his chair, dropping books, talking back and "being fresh" to the teacher.

Miss Jones talked to him kindly, but Jack did not change. He got worse; he neglected his home work; he became sullen and indifferent. Miss Jones ignored the disturbances that Jack created, but this tactic did not bring any noticeable improvement either. She had been kind, understanding, tolerant, and patient—what had to come next? Obviously punishment. Correct. But punishment without effect. At this point, after many months of struggle, Miss Jones asked me to talk with Jack because she was at a loss what to do next.

Jack came to see me. I knew of his behavior difficulties, but I knew almost nothing about his life outside school. I knew only one fact which Miss Jones had told me—namely, that he had an older brother and no father; his father had deserted the family when the child was an infant.

Jack didn't mind talking to me. In response to my questions about the trouble in Miss Jones' room, he poured out a stream of accusations: Oh, Miss Jones! What a teacher! She had been nice once, yes, but she had changed. Now she doesn't care about her students; she only thinks of herself. Jack told me that he had seen her downtown—yes, running around with men. She has nothing else in her head but her own fun. So it went on and on.

Since I knew Miss Jones, I knew that Jack was phantasizing about her. But he was saying something, he was accusing somebody, and I guessed who it was. I said to Jack: "Does your mother think of remarrying?" Jack looked at me with astonishment: "Who told you?"

We can see from this episode that Jack made himself so unpleasant with Miss Jones precisely because he was on such good terms with her. He lived out the conflict with his mother—in relation to a mother-figure, his teacher. The good relation-

ship between Miss Jones and Jack made it almost impossible for the teacher to resolve this conflict herself. Such incidents of sudden disruptions in a good relationship will always happen to teachers. The source of the trouble cannot always be found. The teacher has to understand that children will act out in relation to her; then it will be easier for her not to become personally hurt by the child's action, but to continue to feel toward the child as she did before the crisis.

One reason why it is so difficult to be a good teacher lies in the fact that some of our own childhood problems are still with us. There is nothing abnormal about this. The best we can do is to search ourselves and keep an observant eye on our own reactions as well as on those of the children in our care. How often, when I have discussed with a teacher her classroom problems, have we come to realize that her selective and severe reaction to children's behavior was due to the fact that such behavior confronted her with precisely those transgressions—be it lying or cursing or showing off or messing—which the teacher in her own childhood could control or suppress only with greatest difficulty.

These problems are not solved only by studying psychology; the teacher has to study her own reactions and try to understand herself. Since it is of such great importance to have mature and understanding teachers, training institutions may well consider facilities that will enable young teachers-in-training to receive help with those personal problems which interfere with their professional usefulness. Counseling with a mature and experienced person can be of greater practical benefit than textbook studies in psychology alone. The prospective teacher begins her training during the years of late adolescence, which are emotionally difficult years. Only as far as teachers can themselves arrive at a state of mental well-being can they lay the foundation in children for the growth of emotionally stable adults, with a sturdy capacity for love and for work.

In closing, I will read to you a passage from a lecture by General Chisholm, that great Canadian who has devoted himself passionately to the reestablishment of a peacetime society. He says, in his William Alanson White Memorial Lecture¹:

¹ See "The Reestablishment of Peacetime Society," by G. B. Chisholm. *Psychiatry*, Vol. 9, pp. 1-35, February, 1946.

"The most important thing in the world to-day is the bringing up of children. It is not a job for economic or emotional misfits, for frightened, inferiority-ridden men and women seeking a safe, respectable, and quickly attainable social and emotional status, nor for girls filling in their time before marriage. Fortunately there are recent signs of intellectual stirrings amongst teachers which give some hope. To be allowed to teach children should be the sign of the final approval of society."

MALADJUSTMENT AND MATERNAL REJECTION IN RETROLENtal FIBROPLASIA *

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RETROLENtal fibroplasia (R.L.F.) is a recently discovered disease of the eyes which sometimes occurs in premature infants. Though first described by Terry¹ in 1942, it is rapidly becoming the most frequent cause of blindness during childhood.² Half of the kindergarten class at the Perkins Institution and Massachusetts School for the Blind in 1950-1951 had lost their vision because of this condition. The eyes appear to be normal at birth; within a few weeks there is engorgement of the retinal vessels, which may be followed by hemorrhage, retinal detachment, and other irreversible changes. Many investigators have felt that children with R.L.F. are otherwise normal. Neither blindness nor prematurity seems to exert any adverse effect on their development.

Disturbances of behavior and thinking can be serious complications. Some children with R.L.F. give the impression of mental retardation;³ other cases have been destructive or

* From the Department of Neurology and Psychiatry of the Harvard Medical School and the Psychiatric Service of the Massachusetts General Hospital and the Perkins Institution and Massachusetts School for the Blind. Aided by a grant from the Foundation for Vision.

¹ See "Extreme Prematurity and Fibroblastic Overgrowth of Persistent Vascular Sheath Behind Each Crystalline Lens, I. Preliminary Report," by T. L. Terry. *American Journal of Ophthalmology*, Vol. 25, pp. 203-04, February, 1942.

² See "Retrorenal Fibroplasia—Incidence in Different Localities in Recent Years and a Correlation of the Incidence with Treatment Given the Infants," by V. E. Kinsey and L. Zacharias. *Journal of the American Medical Association*, Vol. 139, pp. 572-78, February 26, 1949.

³ See "Congenital Encephalo-Ophthalmic Dysplasia," by A. C. Krause. *Archives of Ophthalmology*, Vol. 36, pp. 387-444, October, 1946.

assaultive. The prognosis for children who are emotionally disturbed as well as blind is not bright; those who are unmanageable may ultimately, without psychotherapy, be committed to institutions as "feebleminded" or "insane."

Disturbances of behavior occur with some cases of R.L.F., but not with others; the reason for this difference has not been explained. Children with normal vision may become behavior problems or emotionally upset from a variety of causes; it seemed that in R.L.F. similar explanations might apply. A group of children at Perkins were studied to determine possible antecedents of maladjustment. Although a quantity of data were collected, this report will present only certain positive findings. Negative or equivocal results will be omitted. The facts discovered concern attitudes of the children's mothers as related to success or failure at school.

Methods of Study.—Seventeen students with R.L.F. formed the experimental group; thirteen with other types of blindness served as controls. All children had been recently admitted to the kindergarten class, their ages ranging between five and seven. Because they were too young for school grades or course examinations, some technique was needed to measure adjustment at school. The group was small enough for teachers and house mothers to make detailed observations on each child. All children were rated for the following ten specific traits or attitudes:

1. Coöperative. (Obedient to reasonable requests and demands.)
2. Happy. (Free from tears, fears, and temper tantrums.)
3. Plays with other children.
4. Affectionate.
5. Righteous indignation. (Reaction of anger if unfairly treated.)
6. Apparent comprehension of requests.
7. Pride or pleasure in own accomplishments.
8. Ability to carry on simple conversations.
9. Satisfactory maturation for chronological age. (Ability to take care of self, such as eating, toilet needs, motor ability.)
10. Ability to relax and outstanding number of mannerisms. (This applies especially to blindness.)

While the use of any trait names could be challenged, the ones chosen are clear, are commonly used, and seem reasonably descriptive terms to indicate social adequacy.

In scoring, the following scheme was used: "Very" = 3; "Moderate" = 2; "Slight" = 1; and "None" = 0. By this substitution of numerical values for the customary terms, "very," "moderate," and so on, each judgment was subsequently converted into quantitative terms. In this way a composite figure was obtained which represented the average ratings of the ten different traits. The average ratings were considered an Index of School Adjustment for each child.

Ten observers—teachers and house mothers—acted as judges, each judge giving ten ratings for every child. In this way one hundred measurements of social adequacy could be secured for a single student, although in some cases fewer than one hundred ratings were obtained. By averaging together all judgments for each student, any bias or errors of observation were reduced to a minimum.

While data on school adjustment were being secured, a social worker was evaluating the home backgrounds. As many relatives as possible were interviewed, the homes were visited, and family as well as social environments were rated. A large variety of topics had been designated for investigation; all observations were summarized and transcribed on a single large sheet of paper. When the assembled data were inspected, many of them, such as family income, number of siblings, and so on, seemed to be unrelated to adjustment at school, and will, therefore, not be reported here.

One attitude that had been selected for evaluation was maternal rejection. The criteria for this were somewhat subjective. Rejection might be demonstrated in various ways. Some families were unable or unwilling to prepare their children so that they could take their places in the kindergarten. Other parents had so little sense of responsibility that they actually preferred to send their preschool children away from home for extended periods. One mother, who was unmarried, deserted her child completely. In another instance a mother refused to allow her child to learn to walk, apparently to gratify her own neurotic needs by keeping her infant completely dependent. In general, rejection was felt to exist wherever there was (a) lack of real affection for the child; (b) no thoughtful planning or preparation for school; (c) failure to seek adequate medical care; (d) avoidance of

responsibility; (e) gross overprotection; and (f) physical or emotional neglect.

Evaluation of rejection was concerned primarily with the natural parents of the child. It was discovered that the mother's attitude was more important than that of other members of the family.

After the home visits were made and the ratings noted, they were compared with those made by another social worker who knew the family. In most cases there was little difference of opinion between the two observers, each making her ratings independently.

To indicate the type of situation that has been designated as maternal rejection or incompetence, the following notes made by the social worker will serve as illustrations.

"C.B.'s mother said that his aunt, who lived in Texas, was better equipped to take care of him than she was, although the mother seemed perfectly competent and able to do this herself. The impression of the social worker was that she actually did not want to have to cope with him."

"P.H.'s mother was mentally ill and had to go to a mental hospital, so the child was put in a foster home which was subsequently termed unsuitable by the S.P.C.C. After the mother's return home, P. joined her for a short time, but he was very unhappy. A new baby was much favored and P. was continually 'shushed.' Although his mother did not seem to be consciously rejecting him, her attitude was, nevertheless, one of rejection."

"J.S.'s mother had a home that was far above average, but she was preoccupied with her social interests and he was turned over to a nurse girl. His mother gave her children little personal care or affection."

"E.W.'s mother deliberately kept her as a baby in order to secure more help from various agencies. However, after E. had been at Perkins a year, her mother did not wish to be bothered by her care. When vacation time arrived, E. was sent to a foster home. Her mother then had a disagreement with the foster mother, so E. returned to her own home. After a few days, her mother sent her away again--this time to the Home for Little Wanderers. The reason given was that the mother 'needed a vacation,' and E. was 'too trying' and 'demanded too much attention.' The mother was unwilling to take her to the playground or go on walks with her. She felt it was too much trouble."

"D.M.'s mother was actually incompetent and was receiving treatment at a psychiatric clinic. She was able neither to correct the child nor to teach her. Her attitude was one of overprotection."

"B.K.'s mother lived in a charming house, but appeared to be uninterested in B."

"B.U. was illegitimate. His mother deserted him and turned him over to the division of child guardianship. His foster mother was fair."

"M.K. was also illegitimate. Her foster home was not bad."¹

"D.O.'s mother worked, was away from home much of the time, and did not appear to love either of her children. Both of them masturbated excessively."

"N.P.'s entire household was dominated by N.'s grandmother. N.'s mother was tremendously obese and did not permit N. to make any noise because it might bother the neighbors. She was 'never able to do anything with the child.' The grandmother was too old to take proper care of her."

On inspection of the data, it was evident that several children who had been rejected by their mothers were having difficulty at school.

Another set of attitudes that were investigated might be termed "maternal interest." Nine descriptive terms were employed as indices:

1. Physical care.
2. Interest.
3. Affection.
4. Praise and encouragement.
5. Training.
6. Planning.
7. Discipline.
8. Scolding.
9. Punishment.

Notation was made after each item to signify which relatives (mother, father, grandfather, and so on) were concerned with training, in order of importance. Maternal training was, as might be anticipated with small children, encountered more frequently than paternal. The ratio of maternal to paternal items was almost three to one.

Adequacy of training in each instance was denoted by numerical value on a zero to four basis, and the ratings for the several items were added together to secure a measure of maternal training. Thus, L.R. was rated as 3M, 3F for affection (indicating more than average from both parents) and 0 for training. Her total score for maternal-training items was 23 and for paternal, 12.

¹ It is interesting to note that the social adjustment of both these children, B.U. and M.K., was better than that of the children who were brought up by their own mothers if the latter were incompetent or neglected them.

It seemed clear from the work sheet that a number of children with good maternal training were frequently regarded as successful. Since maternal training appeared to be related to good school adjustment and maternal rejection to failure, a more precise evaluation seemed indicated.

Results.—Maternal rejection and maladjustment are closely related in the experimental or R.L.F. group: the child who is not accepted at home does poorly at school. The data are shown in Table I. The relationship is striking: almost every

TABLE I.—MATERNAL ATTITUDE, MATERNAL TRAINING, AND ADEQUACY OF SCHOOL ADJUSTMENT IN RETROLENTAL-FIBROPLASIA CASES

Student	School adjustment	Maternal rejection or inadequacy	Maternal training
L.R.	2.85	0	23
L.B.	2.57	0	17
C.B.	2.53	R	22
C.D.	2.46	0	20
J.W.	2.46	0	26
K.G.	2.45	0	23
R.S.	2.37	0	19
F.R.	2.32	0	19
V.H.	2.31	R	18
R.C.	2.16	*	15
P.H.	1.86	R	7
J.S.	1.67	R	19
L.A.	1.66	R	17
E.W.	1.45	R	6
D.M.	1.31	R	9
B.K.	1.15	R	6
L.P.	.34	†	6

* Parents refused to coöperate, so data not available.

† See case study below. Boy was withdrawn from school by parents.

rejected child was poorly adjusted. The converse also was true. All of the children whose mothers accepted them were well adjusted at school. Predictions regarding success or failure at school might have been made on the basis of whether or not children had been rejected at home; such a prediction would have been correct for fourteen of the fifteen children. The difference has a high degree of reliability. Details are given below under "Statistical Findings."

If we go beyond the fact of mere rejection or its absence, we find that maternal training is related in a positive sense to good adjustment. The five students whose ratings for

maternal training were highest in the experimental group were all well adjusted; the four whose scores for maternal training were lowest were poorly adjusted. The coefficient of correlation between maternal training and school adjustment is +.62. This figure is statistically significant, beyond the 1-per-cent level.

For children with other forms of blindness, the data are shown in Table II. Although blindness in this group is due

TABLE II.—MATERNAL ATTITUDE, MATERNAL TRAINING, AND ADEQUACY OF SCHOOL ADJUSTMENT IN CONTROL STUDENTS

Student	School adjustment	Maternal rejection or inadequacy	Maternal training
J.B.	2.72	0	10
B.U.	2.71	R	13*
C.C.	2.62*	0	21
S.C.	2.50	0	20
D.M.	2.47	R	25
F.S.	2.43	0	23
J.W.	2.37	0	21
M.K.	2.26	R	14*
D.C.	2.25	0	
D.O.	2.21	R	17
P.B.	1.76	R	16
N.P.	1.17	R	13
S.P.	.60		

* State ward.

to many causes, the relationship between maternal care and school adjustment is in general similar to that noted for children with R.L.F. Those whose maternal training is above average (scores of 20 or above) are all well adjusted. These findings are less significant than for children with R.L.F., but, nevertheless, are confirmatory.

Case Study.—The following case is an illustration of a severe disturbance in a child from the study group. He adjusted so poorly that his parents withdrew him from school.

This boy was admitted to the kindergarten at Perkins in September of 1950. He was then seven years, ten months old. His face was rather expressionless, and he constantly poked his fingers into his eyes. He liked to bounce on a bed or couch and would have temper tantrums if he was expected to wear shoes. He was extremely withdrawn, had no interests, and nothing held his attention more than a few seconds. He cried easily, went into rages, and would scream or roll on the floor if any control was attempted.

His behavior was characterized by impulsive movements, such as head banging. His method of orienting himself to his environment was by mouthing things. He refused to eat with a spoon and ate only with his fingers. Frequently he would bite himself, withdraw from a group, and slap himself. He never adjusted to strangers, so that it was impossible to make a good relationship with him. He had very little speech and what he did have lacked originality, and consisted largely of repeating words or phrases that he had heard adults say.

Birth and developmental history.—Delivery was normal after a seven months' pregnancy. Birth weight was three-and-one-half pounds. For two weeks he was in an incubator and was kept in the hospital four months, at which time he weighed five pounds. He spoke a few words at one-and-a-half years, began to talk by the age of two, and by three-and-a-half years was speaking in short sentences. He stood at the age of two and walked without aid at two and a half.

It was not until he was one-and-a-half years old that his mother first noticed "spots" in his eyes. She took him to an eye clinic where a diagnosis of retrorenal fibroplasia was made. This was confirmed by pathological report following operative procedure. His vision was difficult to evaluate, but was apparently limited to possible light perception.

Family history.—Family history was reported negative for blindness or psychiatric illness.

Social history.—The father comes from the Maritime Provinces. His occupation is salesman. He is serious, openly critical of the school, and complains that his child was subject to discrimination and that other children received preferential treatment. The mother is fifteen years younger than her husband. She is a shy, undemonstrative woman who has great difficulty in making a positive or meaningful relationship with this child. She has not been able to help or direct him and is ineffective in training him or coping with his problems. She appeared to recognize some of his needs, but was reluctant to ask for help. When she did, she was unwilling to accept suggestions or advice. The mother seldom took the child out in public, so as to avoid any discussion of his blindness. Her attitude toward his backwardness was complacent. She felt that he would develop when he was "ready." Consequently, she made no effort to teach him in spite of many suggestions that she should do so.

Course at school.—His progress at Perkins was unsatisfactory. His behavior was characterized by continued crying and impulsive scratching. His biting and pinching were a constant threat. He had to eat by himself because the other children were afraid he would hit them. After about six weeks, his father insisted on removing him from the school. The parents blamed the school for his failure to adjust while there. They were bitter and hostile and at first were unwilling even to consider psychotherapy at a psychiatric clinic.

Because of his removal from school near the beginning of the school year, the social worker did not visit his home to make a formal rating of parental attitudes. However, the ophthalmologist who was examining the boy's eyes made a note in the hospital record that was revealing: "The mother has almost no insight."

Statistical Findings.—Although the number of cases (seventeen) in the experimental group is small, it is possible to use

mathematical procedures to determine whether the findings are statistically significant. In the experimental group, the average Index of Social Adjustment is 1.74 for the rejected and 2.47 for the non-rejected children. Using the "student's" *t*-test, the difference between these two averages gives a *t*-score of 3.9. In terms of probability, there is less than one chance in 100 that the difference might be due to chance.

In evaluating the relationship between maternal training and school adjustment, the method of correlation was employed. When we were considering rejection, the experimental subjects could be placed in two categories—rejected and non-rejected children; the method of averages was, therefore, applicable. Maternal training is more largely a matter of degree. With two variables, each of which has been measured, a coefficient of correlation can be obtained. For maternal training and school adjustment the Pearsonian coefficient *r* was +.81. There is less than one chance in 100 of a correlation as large as this occurring by chance.

In the control group the difference is less: (a) In the control group, the average Index of Social Adjustment was 2.10 for the rejected and 2.48 for the non-rejected children. The "student's" *t*-test gives a *t*-score of 1.6 for the difference between these averages. (b) Pearsonian correlation coefficient between amount of maternal training and degree of school adjustment: +.22. Neither figure reaches the 5-per-cent level of statistical significance, and thus may reasonably be ascribed to chance alone.

Although the results for the control group are less significant than those for the experimental group, the differences are in the same direction in both groups and, therefore, tend to confirm each other. The control group is less homogeneous in several respects than the students with R.L.F. In a heterogeneous population the relationship between any single variable such as maternal care and school adjustment is less close than in such a group as children with R.L.F., whose backgrounds are more alike. Methodologically, the averaging of a number of ratings to form a composite index of social adequacy might be questioned. A detailed justification of this procedure would require a lengthy series of computations. These have been performed and indicate that the procedure

is valid: in a multiple analysis of variance, the consistent differences among children in the ratings were much larger than the differences among the ten judges or among the ten traits of adjustment. In the interest of brevity the presentation of this aspect of the statistical analysis will be omitted.¹

Discussion.—Deprivation of maternal affection due to separation from the mother may give rise to retardation,² to behavior problems,³ to neuroses,⁴ or may predispose toward subsequent mental illness.⁵ Other studies indicate traumatic effects of maternal hostility or rejection.⁶ The studies mentioned are based on children with normal vision. Extreme maternal rejection as a source of pseudo-retardation in blind children is being reported elsewhere by J. A. Hallenbeck.⁷ The present study indicates that her findings also apply within the more normal range and that maternal acceptance or rejection are related to adjustment or maladjustment among a group of children all of whom were considered eligible for Perkins.

It should be noted that the situation in cases of R.L.F. is one that is conducive to maternal rejection. The children are all incubator babies; they cannot be nursed, and their mothers may have little opportunity to hold or fondle them until they have reached the age of three or four months. This is a frustrating experience. After the mother has begun to recover from her original anxiety, she ultimately begins to discover that her baby is blind. The resentment that some

¹ I am indebted to Herbert Barry, III, Yale University, for the statistical findings and computations in this paper.

² See "Hospitalization: An Inquiry Into the Genesis of Psychiatric Conditions in Early Childhood," by R. A. Spitz, in *The Psychoanalytic Study of the Child*, Vol. I (New York: International Universities Press, 1945), and "Effects of Psychological Deprivation in Infancy and Subsequent Stimulation," by W. Goldfarb (*American Journal of Psychiatry*, Vol. 102, pp. 18-33, July, 1945).

³ See "Psychopathic Behavior Disorders in Children," by L. Bender, in *Handbook of Correctional Psychology*, edited by R. N. Lindner and R. V. Seliger. (New York: Philosophical Library, 1947), and *Maternal Care and Mental Health*, by J. Bowlby (Geneva: World Health Organization, 1951, pp. 33-34).

⁴ See "Separation Anxiety in Young Children: A Study of Hospital Cases," by H. Edelston. *Genetic Psychological Monograph*, Vol. 28, August, 1943.

⁵ See "Significance of Maternal Bereavement Before Age of Eight in Psychiatric Patients," by H. Barry, Jr. *Archives of Neurology and Psychiatry*, Vol. 62, pp. 630-37, November, 1949.

⁶ Spitz, *loc. cit.*

⁷ Study to be published.

ships enjoyed by his playmates. When adolescence is reached, a sense of despair and a pessimistic philosophy of life, admixed with all sorts of peculiar personality traits, have been established.

Personality depends upon two fundamental drives. The one is for self-expression and the other for activity in conformance with accepted social standards. When these two factors coincide, a pleasing personality develops. In the case of the deformed, the situation is obvious. The deformed child may have every mental and physical faculty for self-expression possessed by other children, but because of his deformity, either he is restrained by others or he avoids the personal contacts necessary for such expression.

Because of this rather unfortunate situation, three reactions may result: First, the child may succumb to his obstacles and accept non-expression as his lot. He may withdraw within himself, become seclusive and shy, and avoid giving play to his instinctual drives. Second, he may develop a compensatory overabundance of self-expression, to satisfy his injured ego. He may become overactive, may overdo things, and in general make a pest and a nuisance of himself in an attempt to draw attention away from his defect. Third, under fortunate circumstances, the deformed child may replace the suppressed modes of self-expression with alternative modes of equal merit. He may find ways and means of expressing his skills and abilities other than those that his defect may prevent or inhibit. This last reaction is the most satisfactory.

A second important factor in the development of personality is the achievement of popularity. Before a handicapped child can gain the recognition of the group, he must overcome the tendency of other children to retain the natural impression of abnormality and undesirability. Many unfortunates are inclined to give in to these difficulties and to make no effort to become one of the group. Others become resentful toward their obstacles and mistreatment. Blame for their failures is either inwardly or openly placed on all manner of circumstances and people. From the sociological point of view, this is the dangerous group. These are the children who may develop objectionable social behavior, since they often cannot obtain desirable employment, may not succeed in matrimonial

ventures, and will not maintain friendships. As a result, they may often resort to criminal activities.

The methods used to overcome these mental traits in children are those that aim at overcoming the physical defects. First is the method of prevention. As far as congenital defects are concerned, little or nothing can be done in the way of prevention. Acquired defects, on the other hand, are preventable.

The second method is that of the earliest possible correction. When a deformity of any type of severity is present, the most important single item in the avoidance of undesirable personality changes is the most complete surgical restoration at the earliest date that is feasible. This is a hard-and-fast rule, and there are no exceptions to it.

It is of the greatest importance to have deformities corrected, if possible, before the child enters school. This is the age of greatest mental and social reaction to deformity, from which every effort should be made to protect the child. Fortunately, there are but few conditions in which at least a partial restoration cannot be made during the first five years of life.

Surgical correction in early childhood is the most valuable method of preventing undesirable personality traits. Unfortunately, early correction of the deformity in some instances is impossible; in others it is not possible to obtain perfect cosmetic results. In such cases, a special program of training must be instituted. This is the sort of training that might be used for any normal child, but with emphasis on certain aspects that are most important for the deformed child.

First, the deformed child must be taught to anticipate difficulties and to acquire a sense of self-reliance. Every effort should be directed toward not allowing him to become spoiled. This training must begin as soon as he is born by not responding with a burst of attention every time the baby cries or frets. As the child grows older, the same principles should be continued.

Since the deformed child is probably destined for one or more operations with some degree of pain, he should be thoroughly prepared for the ordeal. He should not be cajoled into the physician's office dishonestly by being told that it will

not hurt. He should be made to understand that he may be hurt and should at all times be told both by the physician and by his parents exactly what to expect.

The handicapped child is most likely to be deprived of many things commonly sought after for their supposed value, such as money, friends, esteem, beauty, amusements, and romance. Unless such children understand that, regardless of group standards in this respect, true value depends entirely upon the enjoyment they themselves derive, they are apt to do many useless, foolhardy, and even dishonest things to attain their desires, especially for friendship.

The parents of a handicapped child should make every effort to help him readjust his sense of values. Above all, he must learn that true friendship exists only in those who like him in spite of his deformity and irrespective of his possessions or ability to do something to buy their favor.

Speech training is called for in children with cleft palate. Gymnastics are important for children with bone defects and deformities. Cross eyes are greatly improved by exercises to develop the use of eye muscles. Another important part of the training of handicapped children is that directed toward feasible modes of self-expression, and, later in life, toward trades and professions that will not be hampered by the deformity. To be successful, this training must follow the child's own interests and talents and should never be forced or predetermined by parents or teachers. Constructive hobbies, an employment that keep the child happily occupied in his spare time, are of the greatest value. Special training in art, music, athletics, handicrafts, and the like should be made available wherever possible.

Whatever type of compensatory education may be worked out, the child who finds one or more satisfying methods of self-expression that keep him happily occupied, and that receive recognition from others, will develop along essentially normal lines, regardless of his deformity.

CONSULTATION SERVICE TO PUBLIC SCHOOLS BY A MENTAL-HEALTH TEAM

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HERE has been an increasing interest, on the part of those working in the community-health programs, in discovering better approaches to the general problem of maladjustment, especially in children. During the last twenty-five or thirty years, child-guidance clinics throughout the country have demonstrated the effectiveness of an interdisciplinary approach to the study and treatment of the problems of children and their parents. However, there is a growing realization that it is too costly to provide clinics in numbers sufficient to meet all the needs of all communities. Thus it is essential that community institutions and agencies make efforts to do something for people's problems before they become serious enough to require clinic service.

The institution in the community that reaches the greatest number of children and their families is the public school. Most schools are becoming aware that their responsibility toward children goes beyond simply teaching the three R's. More attention is being given to the social and emotional aspects of child development, and genuine interest is seen in establishing a closer working relationship between the school and the home. Some public schools have established "child-study departments," which provide psychological, and sometimes psychiatric and case-work services, to teachers and parents. Children and their parents are referred to community public-health, mental-health, social, and welfare agencies, with the realization that only through joint endeavor can some of the problems that are encountered in the school setting be met. As schools become interested in learning the

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causes in individual cases of maladjustment, they frequently have gone beyond the case discussion to seek consultation on general problems. This educative process has been brought about by mental-health personnel through several methods of approach.

In this discussion, the development of a consultation program in the schools of one community, Phoenix, Arizona, will be described. Medically, consultation is defined as "a deliberation of two or more physicians with respect to the diagnosis or treatment of any particular case."¹ This implies that consultation is a two-way process and that a working relationship is established between the consultant and the consultee. It is usually not implied that the consultant "takes over" the patient for treatment, although it is sometimes mistakenly assumed that this method would be more effective and less time-consuming if the consultant were to do the complete study himself.

A brief description of the setting in which this program developed might be of assistance in understanding how it was put into effect. The Phoenix Mental Health Center was established by the National Institute of Mental Health, of the United States Public Health Service, for the purpose of studying the effectiveness of different approaches to mental-health problems on the community level. In general, it may be said that a public-health approach was used, with the emphasis on understanding causes that give rise to problems and on developing measures to prevent problems from arising or becoming serious.

Five disciplines were represented on the staff at the center: psychiatry, clinical psychology, psychiatric social work, mental-health nursing, and social-science research. The psychologist was the chief liaison between the center and the schools with which it worked.

The center worked with all the schools in the Phoenix area. Four of these systems will be discussed. Although the approach varied with the needs of the school, there were certain common factors, as in the five steps that marked the establishment of a working relationship between the center and a school system:

¹ See Dorland's *Medical Dictionary*. Philadelphia: W. B. Saunders, 1951. p. 356.

1. The usual procedure was to contact the administrators of a school system before talking to staff members. This was not only for the sake of courtesy, but also to avoid the misunderstandings that might develop if those in charge of the school system were not thoroughly familiar with the program. Those providing the mental-health services also found it easier to evaluate the potentialities of a school program if they were first aware of the personalities and philosophy of the responsible authorities.

In these talks with school superintendents, an effort was made to explain the function of the center and to suggest ways in which it might be of service to the schools. In making suggestions, it was most important to avoid giving the implication that "You need us" or "We know something you don't." If a person seeking help can be made to feel not only that problems in human relations are fairly normal, but also that it is possible to secure assistance without feeling on the defensive, an important step has been taken toward establishing a good working relationship.

2. When it seemed likely that a close working relationship with a particular school would develop, the second step was to devote more time to school staff members who were responsible for teacher and student personnel services. In each of the four school systems, these duties were performed by a different staff member. In the first instance, it was the director of child study; in the second, the school nurse; in the third, the principal; and in the fourth, the primary supervisor. Although not all of these had the authority or the responsibility to make changes in school policies and procedures, they were regarded in the schools as the persons most interested in adjustment problems and most aware of the needs of students and their families. These persons were very helpful in making arrangements for joint conferences of center, school, and other community-agency personnel.

3. Equally as important as the person in the school in charge of teacher and student personnel services was the person in the center who had primary responsibility for these school services. The latter's activities were valuable both to the center—especially in the matter of follow-up—and to the school. If school personnel got to know one member of the

staff well, they felt more comfortable in contacting the center through this person. Through personal and professional acquaintance, the mental-health worker seems less threatening to persons in other professions.

In the Phoenix program, the chief contact between the center and the schools was the clinical psychologist on the center staff. In this case, the psychologist had had training and experience as a teacher, an administrator, and a school psychologist, an experience that was of considerable value in establishing close relationships with school personnel. However, other psychologists with different backgrounds could have performed this service, provided they were sufficiently interested and felt that school personnel and the center staff were dependent on each other and could be mutually helpful.

Although the psychologist had primary responsibility for contacting the schools, other staff members from the center also played a part. Most of the school nurses had met the center's mental-health nurse before they met the psychologist. When the mental-health nurse at the center was called by a school nurse in regard to a problem, she was free to discuss the problem and to offer any assistance that might be indicated. Likewise, school counselors, some of whom have had social-work training, often felt more comfortable in calling the center psychiatrist or social worker. Communication among the center staff members was such that it was easy to exchange information about the school's contact with the center. It is probably something of a departure from the usual clinic procedure for a staff member other than a social worker to serve as "intake worker." But, after some experimentation, it was generally agreed that it was more satisfactory for the person primarily responsible for contacts with a particular agency to take charge of the cases referred by that agency and to do follow-up work with it.

4. A fourth step in building up relations with the schools was the demonstration of clinical skills to win acceptance of the center's services. In each of the four schools to be described, the starting point in developing consultative services was an individual case, referred to the center either by the school, by an outside agency, or by a parent. As an integral part of its clinical service, the center worked closely

with parents. As a matter of fact, no child was accepted from a school or any other agency unless the parent was willing to come to the center with the child. This often meant, of course, working with the school in helping the parent understand the importance of accompanying the child to the center. Some schools felt that it was not their function, or that it was too difficult, to work with the families. However, the center was generally successful in getting the schools to work more closely, not only with the families themselves, but with other community agencies dealing with families.

5. It was undoubtedly the success of the center's follow-up work with individual cases that led to the consultation services. The center did not feel that its function should be to make a diagnosis, give treatment, and then say to the school either, "This is what you should do, and the pupil will be all right," or, "This is what we have done and now he is all right." Although the problems of each child were different, there were enough factors in common for the school to recognize the similarities and to be led to discuss other situations with the center.

This led to consultation about the problems of other children before they were referred to the center. Then came discussions of general problems encountered among students and how they arise, without particular reference to any one child. As conferences continued, more school staff members were brought into the discussions. Requests for group discussions came both from the administrative and from the teaching staffs. Parents who had been helped at the center began to request staff members from the center to appear on parent-teacher-association programs and to participate in parents' study groups. Requests like these came from all but one of the four school districts with which the center worked.

The largest of these four systems in the Phoenix area, with a school population of more than 12,000, had a well-organized child-study department, headed by a clinical psychologist. The system also had an assistant psychologist, a speech pathologist, and ten counselors, as well as a staff of school nurses. The chief contact with this school district was through the director of child study. The principal type of service given by the center to this system was psychiatric

consultation, with emphasis on work with families as well as individual treatment for children. The number of cases actually referred was small because of the competence of the child-study staff in handling its own cases. However, the counselors discussed various problems with members of the center staff, and there was a series of joint staff discussions on problems of a more theoretical nature.

When questioned about the value of the center's services to his program, the director of child study stressed the importance of the consultation work of the center, not only for his particular school system, but for the community as a whole. He especially appreciated the value of consultation between the center and the school counselors. However, he felt that the greatest assistance had been the center's specialized services to disturbed children and their families and the center's initiative in calling inter-agency conferences.

The second school system with which the center worked was just outside the city limits of Phoenix, and had a centralized elementary-school population of about 2,000. In this particular school, the school nurse was the person who seemed most familiar with the emotional problems of children, as they came to her office for help. She was also responsible for following up attendance problems, and was quite aware that many absences were due to emotional problems as well as to physical illnesses. In this school, the administrative and supervisory staff were also aware of these problems and eager to do something about them. During the first year of working with this school, the center psychologist spent a half-day each week at the school, serving as a consultant. During these visits, several children were seen individually for diagnostic purposes, because of learning problems or social adjustment. In most instances, the parents of these children came to the school to talk with the nurse or the psychologist. At the end of the school year, it was apparent that no great changes had taken place in the learning ability or behavior of the children seen, especially among the pre-delinquents or delinquents. However, in discussing the value of this type of service to the school, the nurse declared that she had noticed a considerable change in the attitude of the teachers, not only toward the children who had been seeing the psychologist,

but toward other children as well. She said that this change was noticeable in the manner in which teachers discussed with her the problems of different students.

Another activity during the first year's work with this school was a series of discussions with the adult-education group of the school's parent-teacher association. Since the group was small, the discussions were very informal and were concerned principally with more or less normal behavior problems of children at various age levels. A different member of the center staff accompanied the psychologist to each of the meetings.

During the second year, consultations with teachers at this school were generally on a group basis. In order to meet the need for consultation on individual cases, at least two staff members from the center went to the school for a two-hour conference with all interested teachers once a month. In addition, a series of general discussion meetings were held with teachers. The teachers divided their group on the basis of grade level and chose the topics they wanted discussed. A psychiatrist and the psychologist from the center were group leaders in these discussions. A similar series of meetings was held with parents. The last discussion period of the school year was a joint meeting of parents and teachers.

In appraising the effectiveness of the four types of services provided by the center—study of individual cases, consultation with teachers in regard to individual cases, teacher discussion groups, and parent discussion groups—it was the opinion of the administrative and supervisory staffs that the discussion groups with teachers had been of the most value. The superintendent said that the teachers had first thought that it was the center's responsibility to solve the individual case problems for them, but had later come to realize their own responsibilities in these problems. It was his belief that the school now had a better idea of its rôle in school mental-health problems. He was pleased that the center's recommendations often indicated the same course of action that the school had believed should be followed.

The school nurse felt that her work had been made more effective, particularly in regard to home situations. She believed that more parents had become interested in the emo-

tional aspects of rearing their children, and that the center had been responsible for this change in attitude. It was also indicated that the school had previously distinguished between learning problems and behavior problems, but now was attempting to understand the child in a more integrated sense.

The third school system with which the center worked also had a population of about 2,000, but in two separate schools. Again, the initial contact between the center and the school system was through an individual referred. However, as the relationship developed, the principals of the two schools became the primary contacts. The principal of the larger school was very much interested in discussing different aspects of supervision and teacher training. He was interested not only in the adjustment of the individual, but also in the effect of the individual upon the group.

During the first year, the psychologist was asked to talk before the parent-teacher association, at which time home and school relationships were discussed. After this meeting, the superintendent and the principal asked for a series of discussions with the teaching staff. At these sessions, the problems of many individual pupils were discussed and, as a result, it was decided that the center would try to develop a regular consultation service with this school.

Fewer individual children were seen at this school than at the one previously described. Instead, more time was spent with members of the staff. The conferences, at the outset at least, were usually between the principal and the psychologist, although later the principal often asked some of his teachers to these conferences. At times a child under discussion was observed in the group and then the situation was discussed with the principal and teachers. These discussions seemed to give the school staff a feeling of confidence in the action to be taken. There were also some individual cases referred to the center, and a few children were seen at the school.

In regard to the school's reaction to the service given, the principal in this district said, "There isn't a pupil whom the center has seen who isn't doing better this year as a result of the contact with the center." The principal also made a statement, "We have been helped as we wanted to be helped."

The center staff placed great emphasis upon this statement, as it was felt that it would be difficult, if not impossible, to help either people or agencies in any way other than in the way they wanted to be helped. Another statement made by the superintendent was, "Our staff has no feeling that you have criticized them as teachers."

In attempting to decide whether the assistance given to individual cases was more important than the assistance given to teachers, the superintendent stated that it was about "fifty-fifty." However, the supervisors placed the assistance given to teachers first. The principal further declared, "One thing that the center has done that never has been done before was to call us in whenever another agency had referred a pupil from our school to the center." When asked to give criticisms, the school staff agreed that the center was not able to give enough time. It was in this connection that the need for specialized mental-health personnel in their own school system was recognized.

The case of the fourth school differed in that the center did not make the same kind of early contacts as were made with the other schools. Referred children who lived in this school district came from sources other than the school. There were six children from this school who had been to the center for treatment. The center requested conferences with the school, as had been done in the case of all school children who needed treatment.

During the middle of the second year, a letter came from the superintendent of the district asking if a joint conference could be arranged, as he had heard that the center worked with schools as well as with families. As a result of his interest, a regular consultation was provided for this school. The main contact here was with the primary supervisor. She and other teachers frequently contacted the center to report on the progress of children who were coming to the center. There was a tendency for the case-consultation conferences to be so well attended that it was difficult to carry on a general group discussion. However, at the end of the first year, the teachers requested discussion groups about general problems rather than case conferences, so that more teachers might participate.

In discussing the value of the center's work with the school,

the supervisor stressed the importance of consultation service and requested more time for case consultation as well as discussion groups for teachers. Accordingly, in the second year there was more active participation on the part of the school staff as well as greater demands made on the center.

The center staff was pleased with the relationships established with the schools. There was a feeling of mutual respect professionally and also a feeling of friendliness on the part of both groups. Although there was a healthy interest in regard to the problems of individual children, there was an even greater interest on the part of the teachers as to ways in which they could increase their own understanding of all of the children in school. As the center staff discussed research interests with school personnel, the latter not only showed interest, but also expressed a desire to coöperate actively with the center in trying to discover possible causes of behavior problems as well as effective methods of preventing such problems from becoming serious.

In summary, several comments may be made regarding the approach used in developing working relationships with the schools, the use of several disciplines in consultation, and the effectiveness of this type of service as seen both by the school and by the center.

Prior to developing a working relationship with a school, some assumptions were made. One was that in order to gain the confidence of the school personnel, it would be necessary to become acquainted with them on both a personal and a professional basis. Another was that, after a brief statement of center function, school personnel would be able to decide better than center personnel how the school could make use of the services. A third assumption was that, having worked on the level of service the school wanted (in the instances described, this was on an individual-case basis), there would be a readiness to make wider application of mental-health principles. In general, it was felt that these assumptions were justified in practice. It was also felt that if the center had been more directive and authoritative in its approach, the way would have been blocked for further work with the schools.

Several disciplines with different training and theoretical

backgrounds were represented on the center staff, in keeping with the concept of a multi-disciplinary approach. These differences were superimposed on basic differences in the personalities of its members. The problems of communication that developed were reduced in part by an attempt to maintain a permissive attitude, by recognition of the potentialities of fellow workers, acknowledgment of responsibility in appropriate areas, and the provision of means whereby each worker could reasonably expect to satisfy his needs. The center staff was not without its problems in attempting to reach a common understanding, but in community relations an effort was made to present a unified front. The contributions of various disciplines in particular aspects of consultation services are felt to merit more detailed study.

Presenting objective data on the effectiveness of efforts in the mental-health field has proved difficult. This study is no exception. Possibly it can be said with a fair degree of certainty that the schools have welcomed this type of service. Whether the end results are beneficial or not will depend to a great extent upon one's criteria of evaluation. Certainly one cannot say that this approach is the only one to follow nor can it be said that the results show the "greatest good for the greatest number." A different approach would be needed in order to answer such questions with any feeling of satisfaction. Perhaps one primarily gains the feeling that the trend seems to be in the direction of a better understanding of the rôle of various community members involved in handling the growth and development problems of children. Certainly the results of this relatively short period of study would indicate that this method of approach leads to a mutual learning experience both for the center staff and for the school personnel, and that this should result in better services for children in their school experiences.

THE GOALS OF MENTAL-HEALTH EDUCATION COMMONLY SELECTED BY A GROUP OF EXPERTS*

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CONCOMITANT with the mushrooming growth of interest in mental-health education, there has been constant pressure from many sources to evaluate the effectiveness of such programs. Serious and sincere questions have come from members of all disciplines in the field of mental hygiene, including those engaged in educational efforts, those in a clinical setting, and those representing other areas of endeavor closely related to the education programs. Further, equally pressing and sincere questions are already appearing from the sources of financial support.

As a part of its preventive program, the Michigan Department of Mental Health has for approximately five years maintained an education division which is engaged in a state-wide program of mental-health education. Cognizant of the importance of questions regarding the effectiveness of such education, this division, in collaboration with the research division of the department, set out to develop a series of projects designed to evaluate the various aspects of the program within the framework of a continuing practical service. This latter point was considered important if the evaluations were to be of use to those actively engaged in education efforts.

At the outset, it was assumed that such education is worth while and necessary in view of the widespread mental-health problem, the limited clinical facilities available to deal with the problem, and the commonly accepted premise that therapy *per se* is not necessary or advisable for all people or for all problems. Furthermore, many aspects of mental-health problems seem more amenable to mass-education techniques and

* This report is the first of a projected series, now in progress, involving evaluations of procedures in mental-health education in the Michigan Department of Mental Health.

perhaps more immediately solvable through such procedures. Thus, we were interested in developing projects designed to evaluate the various techniques used, with particular emphasis on their effectiveness in changing the level of information, and if possible in changing the attitudes and the behavior of people. Which people were reached most effectively was also to be a primary consideration.

It immediately became obvious that a major problem involved in evaluative studies was the suspected variability and lack of integration of the objectives of the many professionals working in the field. Without a reasonably concise pattern of goals to be achieved, attention to techniques becomes comparable to the development of a well-designed experiment, the results of which have no application beyond the experiment itself. The means to an end become the end in itself, and the pressing basis for the whole program becomes lost in a discussion of the procedures, or at least in a series of studies difficult to relate to one another or to a comprehensive program. One cannot peruse the psychological literature without recognizing that this situation is not unique to the field of mental-health education.

Therefore, it appeared to us that a very important primary project was a determination of the basic goals or objectives of a program in mental-health education. It seemed that the most feasible means to make this determination was to consult a selected group of professional people, including not only mental-health educators, but also practicing clinicians and those producing materials. We assumed that if experts from all disciplines were consulted, a list of objectives could be compiled that would be based both upon theory and upon experience and that would attain objectivity through the common goals listed independently by these experts. In other words, if several experts independently listed a certain goal for mental-health education, we felt it could be considered an objectified goal because it commonly appeared in the thinking of those qualified to discuss both the theoretical and the experiential aspects of the problem. This procedure is essentially the commonly used experimental technique of the agreement of independent observers.

To execute the plan, 86 experts were requested by letter to enumerate and discuss those objectives which they believed

important for a mental-health-education program. The letter of request explained the plan to establish a list of goals that might ultimately contribute to a basic unified approach for the field of mental-health education. It was further explained that the list established in this manner might be used in developing evaluation projects. Thirty-six of the requests went to psychiatrists, 20 to psychologists, 8 to social workers, and 22 to mental-health educators.

For purposes of this study, members of disciplines other than these four were considered as mental-health educators and were contacted because of their contributions in that area. We do not pretend, of course, to have contacted all or even most of the experts in the field, and we made our selection without regard to the number of participants included from a particular discipline. We attempted to get some balance between those with a more theoretical orientation and those more immediately concerned with the practical aspects, and we wanted at least some representation from the various orientations involved. The selection of names was made by consulting the membership lists of the American Orthopsychiatric Association, the American Psychiatric Association, the American Psychological Association, the American Association of Psychiatric Social Workers, and the publishers of lists of mental-health-education materials. An "expert" is defined for this project as one who is a member of one of the above groups and who has attained some prominence in his area of specialization. The selection of these people was made by a committee of three, who pooled their judgments on whether or not to include a name.

Sixty-four of the 86 experts replied to the letter, in some instances after a follow-up letter had been sent. A tabulation of the requests sent and the replies received gave the following results:

<i>Discipline of addressee</i>	<i>Number of requests</i>	<i>Number of replies</i>
Psychiatrists	36	29
Psychologists	20	14
Social workers	8	7
Mental-health educators	22	14
	<hr/> 86	<hr/> 64

We were somewhat amazed at the enthusiastic response our request received from the experts we consulted. There were those, of course, who did not reply at all, and there were some who did not believe the project was feasible. These, without exception, stated that a committee of key people could perhaps develop a list of goals. We had previously rejected this suggestion because such a measure could not give us the independent opinions based on personal experience which we were seeking from this preliminary investigation. It seemed to us that a first step was to determine the common objectives selected *independently* by a group of experts practicing in the various facets of the field of mental hygiene. Even experts react to the pressures of group discussions, and it has been common experience that some members of the group will be heard only rarely, that others will be vocal enough to direct the entire group, that some ideas will be discussed beyond the point of fruitful contribution, and that in the process of the discussion many ideas will be lost or never expressed at all.

It is the authors' hope that this first report may contribute the framework from which a committee of experts may begin to discuss and elaborate the objectives of the mental-health-education program. As a result of such discussion, it is hoped that a long-range program can be developed, with concomitant plans for the ultimate evaluation of our success in achieving the goals for which we strive.

The analysis of the replies presented a further problem in relation to objectivity. If we were to assume that any set of goals we derived from the letters was objectified because of common mention by a group of experts, we had to analyze the responses in some manner that would reflect the overlap of ideas and not the bias of the person making the analysis. To circumvent this possibility, two members of the research staff read all the letters and noted the objectives discussed in them. Each staff member then combined the results of his first analysis into the major goals or areas that evolved in his notes. Sub-goals which further elaborate the major goals were also compiled from the original analyses. The results obtained by these two staff members were then compared and combined into a master list of major goals, each with a list of sub-goals related to the major area. Identical objectives appeared in the analyses of both staff members.

The next step was to have all the letters read again, tallying each reference to a major goal and also tallying a reference to any of the sub-goals. In this way the five major goals and the elaborative sub-goals most commonly selected by the experts were determined. A commonly selected goal is defined here as a goal suggested by at least 20 of the experts. This figure was arbitrarily selected with two considerations in mind. The first was the purpose of the project—to determine *common* objectives of mental-health education—and the second was the desire not to eliminate objectives recognized as important by many, but not a majority of the experts. By the use of this method,¹ the following objectives were defined:

- I. Disseminate knowledge about and develop understanding of the underlying principles of mental health (with emphasis on the aspects related to the individual adult):
 - A. Stimulate optimal personal development through knowledge of existing information and understanding of self.
 - B. Improve the capacity of individuals for successful interpersonal relationships.
 - C. Develop awareness of the importance and attainability of mental health and its influence on the total life pattern.
 - D. Disseminate knowledge of the principles of personality development.
 - E. Develop understanding of the rôle of unconscious motivation in determining behavior.
 - F. Promote understanding of the interrelationship of environmental and personal factors in determining personality development.
 - G. Disseminate knowledge of basic needs and means through which individuals and society can provide for meeting these needs.
 - H. Develop publications to inform the public about various aspects of mental health.
 - I. Help individuals to seek professional treatment and

¹ There are no quotations from the letters since we did not request such permission, and because in some instances we were asked not to publish or quote the material offered.

- consultation freely. (It was frequently cautioned that this objective must be realistically related to the available facilities as well as to the need for such services.)

II. Promote the development and maintenance of good mental health in children:

- A. Inform parents and others responsible for child care about the generally accepted theories of child development and help them understand problem behavior as indicative of a need for help.
- B. Inform parents and teachers of the importance of environmental influence on child development.
- C. Teach parents the rôle of the family in forming personality, emphasizing the importance of satisfying parent-child relationships, especially with regard to giving children assurance of love and security.
- D. Train teachers and school administrators in child-development theory, in the elements of the psychology of adjustment necessary to recognize children with problems, and in developing the ability to maintain a mentally healthy classroom atmosphere.
- E. Promote screening of personnel as a part of school administration in an attempt to assure well-adjusted teachers.
- F. Develop mental-health curricula in school systems to help children make satisfactory adjustments (including guidance courses, art-of-living courses, marriage-and-the-family courses, pupil discussion groups, guidance services), and, in general, adjust school practices to children's emotional needs.
- G. Develop mental-health literature appropriate for school children of all ages.

III. Create informed public interest in the problems of mental illness:

- A. Develop public understanding of the incidence and nature of mental illness and eliminate misconceptions about it.
- B. Teach the public that mental illness is preventable and curable and promote early treatment. (Several

experts stressed the importance of not misleading people with regard to the curability of all mental illnesses.)

- C. Inform the public about existing facilities for the care of the mentally ill and develop interest in expanding such facilities, with an understanding of the economic factors involved.
- D. Help people understand how to live with and coöperate with those who are recovering from mental illness.

IV. Develop the community aspects of the mental-health program:

- A. Teach the relationships between cultural values and mental health and ways to modify social concepts not conducive to mental health.
- B. Coöperate with groups attempting to remove cultural and social detriments to good adjustment, such as prejudice, insufficient recreation, poor housing, and insecure employment situations.
- C. Develop the local facilities that attempt to help people maintain mental health and create public support of these facilities.
- D. Influence the welfare of individuals by indoctrinating in the principles of mental health those at the policy-making level in the community's various institutions.
- E. Develop inter-agency and inter-group coöperation among those carrying out programs concerned with mental health, including both the clinical and the educational aspects.

V. Promote training of personnel:

- A. Develop more training in psychiatric information for physicians.
- B. Teach mental-health principles to members of allied professions, including nurses, ministers, judges, parole officers, educators, and hospital administrators.
- C. Teach principles of mental health to publishers of

- children's books and producers of radio, television, and theater programs.
- D. Develop interdisciplinary understanding of the contribution each can make in coöperative efforts for mental-health education.
- E. Further develop training in mental-health education as a profession and give clinicians more training in educational techniques.
- F. Train volunteer workers for those aspects of mental-health programs which they can handle adequately.

Referring to the tabulation of replies received, the reader will note that most responses came from psychiatrists, which in effect means that any list of goals developed will emphasize their opinions. Should they differ from others in the field, this emphasis will have an important effect in that the point of view of other experts may be obscured. Because of this situation, we attempted a simple breakdown of the results according to disciplines. The problem of the percentage obtained when using a small number was recognized—*i.e.*, when there are only five people in a group, the opinion of one person makes a difference of 20 per cent in the results. Therefore, we have presented the number of respondents selecting each goal instead of giving percentages which might be misleading. Regardless of this circumstance, there is considerable agreement among the members of these related fields, since limited differences were found between groups. The number of respondents in each group who listed each of the goals was as follows:

Goal	Number of each discipline selecting each major goal				
	Psychiatrists (N-25)*	Psychologists (N-9)	Social workers (N-5)	Mental-health educators (N-9)	All groups combined (N-48)
I	13	6	2	8	29
II	16	7	3	6	32
III	11	2	3	6	22
IV	11	4	3	6	24
V	9	3	4	4	20

* The number for each discipline may not agree with the number shown in the tabulation on page 598, since in some cases it was impossible to summarize or otherwise interpret the response.

It will be seen that marked agreement exists between disciplines, although, comparatively speaking, the mental-health educators emphasize promoting knowledge of mental-health principles and the psychologists underemphasize promoting knowledge of the problems of mental illness. The social workers are somewhat more concerned with professional training than the others, but it appears to be training for allied professions, which may be due to their more extensive work with these groups. The psychiatrists show no marked deviations from the results obtained for the members of other disciplines.

The five major goals that were developed appear to break into separate areas motivated by the different forces that underlie the entire mental-health-education program. Goals I and II (develop understanding of mental-hygiene principles and develop good mental-health in children) may be based on the underlying principle that education, as preventive mental-hygiene, attempts to reduce or prevent anxiety through the development of the individual's insight into his motivations and through the relaxation of superego function. That this is possible through mass education is apparently assumed, or at least hoped for, by most of those engaged in the mental-health movement. Threatening or "scare" literature seems to have been produced as a part of the effort to develop these primary goals; consequently we would like to stress the importance of presenting fundamental concepts to the public constructively and with as little threat as possible. The use of threat to gain support for the mental-health program is an example of defeating the effort to reach a long-term goal—anxiety reduction—in order to reach an immediate and perhaps more superficial goal.

Goals III and IV (informing the public about problems of mental illness, and development of the community aspects of mental hygiene) apparently are considered important partially because of the continuing need professionals find to inform the public about practical aspects of the mental-hygiene problem in order to enlist public support for already developing programs, for new programs, and for various projects undertaken to solve some of the mental-health prob-

lems. This might be called a drive for public understanding and, thereby, support of the mental-health movement.

Goal V (promoting professional training) is a practical goal that may have become apparent to the experts in their efforts to achieve the other objectives which seem more related to a fundamental philosophy. In a sense this goal must be reached, at least to some degree, before it will be possible to achieve the more fundamental objectives of mental-health education.

A well-defined education program should without doubt consider all of these goals in terms of the available staff and the particular skills of members of this staff. To achieve some objectives might require a minimum of staff effort and time might be allotted accordingly. Some objectives might be best attained through coöperation with other programs rather than through the direct service of a mental-health-education staff.

Mental-hygiene societies and allied lay groups are doubtless key sources of personnel to attain some goals and they are certainly the groups in which much of the education program will first take effect.

With the objectives outlined and with the development of an integrated approach by coöoperating groups and agencies, it should be possible to conduct an effective mental-health program. Such an organized effort should make it possible to determine periodically the measure of success achieved. The present problem for research, then, is to develop practical and meaningful measures of the effectiveness of the various techniques used to obtain the objectives and to apply these measures to the continuing education program.

THE DYNAMICS OF THE MARITAL RELATIONSHIP *

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IN an analysis of the dynamics of marriage, two factors need consideration: the persons and the marriage, the characteristics of the individuals involved and their interaction in the marriage.

Two unique personalities come to marriage. They have characteristics common to all human beings, but they also have individual characteristics due to their sex, their genetic inheritance, the ideas, feelings, and attitudes that they had acquired as a result of their development in a particular family, in a particular place in the family constellation, and in a particular social group. The kind of marriage the two will make will, to a considerable degree; therefore, depend upon the kind of people they are.

There is, however, also the other factor involved in marriage: the interrelationship that results from the interaction of these two different personalities. In marriage the two individuals have to adjust themselves to each other as well as to many other new people and situations not of their own choice—the spouse's family, relatives, friends, and a new and different way of life. They have to be able and willing to give up much of their personal freedom, which they may have struggled long to achieve, in order to make a satisfactory adjustment to the new relationship. They must be able as well as willing to share the basic satisfactions that men and women seek in marriage—the security of love and companionship, sexual satisfaction, a home, and a family.

To make the many compromises and adjustments required for a satisfactory marriage, a person has to have a flexible

* From a paper delivered before the Schilder Society.

and mature personality, he has to be physically and emotionally grown up. But emotional maturity alone is not enough. It may give the individual the potentiality for making the required adjustments, but it does not necessarily insure a good marriage. A person's own maturity will not inevitably guide him to choose a partner who is also mature; he may fall in love and marry a person who is not at all grown up, who has a character disturbance, or marked neurotic tendencies. Later, he may resent the mate's personality deficiencies and inability to grow and develop, and may not be willing to accept the fact that under such circumstances most of the adjustments have to be made by him.

The men and women we see in marriage consultation are of varying degrees of emotional development—some are adult and well-balanced, some are immature or with neurotic traits, and some are neurotic or psychotic. These people, the neurotic or even the psychotic, whom we see in our service, would not normally be seen in psychiatric offices, hospitals, or clinics because, as long as they are single, they manage to get along fairly well in life. When they marry, however, they become disturbed because their behavior is resented by their mates and because they are unable to make the required adjustments. They are found fault with and blamed for character traits that they themselves feel to be natural to them, and not subject to challenge or change. Seldom do they receive the type of acceptance that makes possible modifications of personality or even growth toward maturity.

Men and women seek love and emotional security in marriage. The need for emotional security, vital to the infant and the growing child, remains a need throughout the life of the adult as well. A mature love relationship between a man and a woman is a source of such security. Mature love differs from childish love in that it seeks not merely the satisfaction of self, but even more so the satisfaction of the beloved partner. It is also different from romantic love, which is a state of illusion in which the loved one is endowed with all the qualifications one would wish to find in him or her. Since our culture has placed a high value on romantic love, many men and women regard it as the basis for marriage. The realities of living, however, bring about a rapid disillusionment. Love

of the kind to marry on is one in which the man or woman is fully aware not only of the assets, but also of the deficiencies of the partner. These are accepted as part of the individual, to be understood and lived with.

Mature love is normally expressed to the person loved with word and gesture, with signs of affection and tenderness. Yet American cultural values do not encourage the unrestrained expression of emotions. If it is manly not to show feelings, but to keep a stiff upper lip in the face of fear, grief, or anger, it is also not manly to be too emotional, demonstrative, or "womanlike" in feelings of affection and love. Lack of demonstrativeness, however, often becomes a source of irritation and resentment. "I know he loves me, but why doesn't he say so?" or, "Why doesn't he show his love in some way?" is a frequent complaint.

A husband is often perplexed at his wife's insistence upon a greater show of his love for her. He fails to understand that she has a far greater need for evidence of love and affection. This need is due to a fundamental difference in their emotional development. Both boy and girl start life with a greater dependence and attachment to the mother than to the father. In return, they give her the greatest share of their love. For the boy, this emotional relationship remains unchanged: as an adult, he again gives his love to a woman. The girl, however, must make a profound shift from mother love to father love if she is to be able to accept fully her husband's love. Hence, she seems to have a constant need for reassurance and support from her husband.

Mature love and an ability to express it and give it freely is an essential base for a good marriage. Not all people, however, possess the same degree of feeling or can demonstrate their feeling with equal facility. If we accept the fact that people have varying degrees of emotional capacity, then all one can expect is for the individual to express his feeling to the extent of his own capacity.

Another satisfaction men and women seek in marriage is a mutual response in their sex relations. A man and woman fully grown to maturity should normally bring a healthy heterosexual attitude to their marital relations. This will express itself in a mutually pleasurable response, with a

culminating climax or orgasm for each. This good feeling extends to other areas in their relationship and facilitates the required adjustments.

But in the sexual sphere, also, many problems arise. The couple may be ignorant of the basic anatomical and psychological aspects of the sexual relationship, or they may be inhibited by cultural taboos and superstitions, by distorted attitudes, conscious or unconscious anxieties, and guilt feelings. Even though, intellectually, they may come to accept the normality of sex, they may yet be unable to free themselves from the emotional ties that bind them to their fears and inhibitions.

Constitutional variations in sexual capacity also have to be considered. First, there are the basic physical and biological differences between men and women. The male genitalia are external and superficial, while the vagina is internal and less subject to contact and stimulation. Erotic sensations in the male are usually felt chiefly in the sexual organs; in the female they are more diffused and they are rarely felt in the vagina before sexual intercourse has been experienced. In women, sexual desire is more cyclical and depends to a larger degree upon inner physiological and emotional stimuli than it does in the male. A woman, however, can accept the male at any time, even when she has no desire at all, while a man can function only when he has become stimulated and has erectile capacity.

Male arousal and response, in sex relations, furthermore is generally faster than that of the female. Many women have great difficulty in achieving orgasm, or can reach it only through clitoral stimulation and not at all through vaginal contact. Kinsey maintains that there is no difference between clitoral and vaginal orgasm, yet women who achieve orgasm both through clitoral and vaginal stimulation recognize a definite distinction. Many women are very much disturbed when they find that they can achieve orgasm only through manual clitoral stimulation and not through coitus. The reasons for this orgasm failure are still not clear. Is it due entirely to neurotic mechanisms? Is there possibly also an anatomical basis? Do the size of the clitoris, its distance from the vaginal orifice, the nerve distribution within the

vaginal wall, the degree of genital development play a rôle? Certainly, until we learn more, we cannot eliminate the possibility that sexual maladjustments may be due to constitutional and anatomical, as well as to emotional, factors.

Since stimulation of sex desire is primarily psychic in origin, the type and strength of the stimulus required in a given instance is subject to many variations. With child-bearing and age, a woman's body changes. She becomes less exciting and stimulating. The frequency and intensity of the sex urge may differ considerably between husband and wife. Sometimes he has more desire and she resents his frequent approaches; and at times her sexual desires may be greater or more frequent and the husband will find difficulty in meeting her needs. Her demands for prolonged lovemaking, which are frequently necessary for her physical and emotional satisfaction, may at times be irksome to him. If she takes the initiative and tries to arouse him, he may resent it, while she, in turn, may take his attitude as a sign of rejection or of his loss of feeling for her as a woman.

The ability to work out a mutually satisfactory sex relationship demonstrates an ability to consider not only one's own needs, but those of the mate as well. When the frequency of desire varies, as it so often does, working out a pattern satisfactory both to husband and to wife implies a willingness to change one's own rhythm or to give up some of one's own needs for the sake of the other. When the woman's response is slower, as it frequently is, the man's control of so powerful an impulse as the sex force shows evidence of thoughtfulness and consideration for the woman who is sharing this experience. Similarly, the wife who is willing to accept her husband and give him the satisfaction he seeks, even though she may have little desire at the time, shows the depth of her feeling for him—her pleasure in giving him something he needs and desires. The satisfactions of a mate's needs may be justifiable even when they are not necessarily mutual. The man should, however, be able to accept his wife in the sex relations without resentment, even if she does not have a complete response.

A third element in marriage is the desire to build a home and family. Most married couples want children, and only

a small percentage remain voluntarily childless. There is a basic, powerful urge in women to conceive and to bear children. The use of scientific contraceptive methods merely makes possible the planning of parenthood. Planning and spacing children have become increasingly widespread among all social strata.

Yet this ability to plan has created new problems. It places the decision of whether and when to have a baby upon the parents themselves. Husband and wife do not always agree about the timing or the number of children. Nor do they always agree on the type of contraceptive to be used. The husband may wish the wife to take the necessary precautions, and she may want him to share the responsibility. Rejection of contraceptive methods or irregular use is sometimes a sign of unconscious conflicts regarding pregnancy and motherhood, or else an indication of a strong desire for a child.

Infertility can also become a difficult psychological problem in marriage. The lack of ability to procreate is a severe blow to self-esteem, and the knowledge of it leads to a marked feeling of inadequacy. Conversely, there may also exist deep-seated anxieties which contribute to the infertility. In any event, the resulting conflicts may lead to much marital dissatisfaction.

Mature mutual love, sexual responsiveness, and sharing in parenthood are the dynamics of a happy, healthy, stable marriage. Because of differences in personality, in physiological capacities, or in emotional needs, conflicts may arise in any of these areas. Other factors, too, may lead to marital disturbances. A married couple does not live in isolation. Cultural, religious, and educational differences, social and economic factors may be sufficiently acute to become a cause of serious difficulties in a marital relationship. Unemployment, illness, lack of adequate housing, and particularly in-law interference frequently cause anxieties and conflicts in a relationship that might otherwise have been very satisfactory.

Changing social, economic, and cultural conditions are modifying the structure and functions of marriage and the family. The social mobility that exists in the United States leads to the marriage of people from different social, educational, and religious groups, and this adds to the problems of

adjustment. Technological advances, particularly the increasing participation of women in industrial and professional life, the progressive diminution of her economic dependence on her husband, labor-saving devices in the home—all of these are to-day affecting the character of marriage and family life.

The newer concepts of masculinity and femininity conflict with the stereotyped male and female rôles. The latter implied an aggressive, strong, dominant male and a submissive, weak, gentle female. A man went out of the home to earn the money to maintain the household and a woman remained in the home and limited her activities to being a wife, mother, and homemaker. In every culture the male has been the "provider" and the woman, the "preparer." To-day these rôles are being modified. A woman may be as capable in industry and earning capacity as a man is; she may even be able to earn more money than he does. When she works outside of the home, she expects him to participate in the household tasks. If she helps with "providing," then she would like him to help with the "preparing." This change in the previously well-defined rôles of men and women adds new stresses and strains to the adjustments in marriage. Many people are confused by these factors and are not ready or not equipped to recognize and accept them.

The gradual transition from an authoritarian, patriarchal family system to a democratic organization brings further problems. One of the many aspects of this newer concept of family life is the problem of mutuality. When women were submissive, they had few expectations, whether social or sexual. They were satisfied with their rôle of wife and homemaker. Now they expect to have mutual interests, mutual tastes, mutual attitudes to families and friends, and also mutual sexual gratifications. Since this is not always possible, one or the other or both may come to feel that there is something wrong with their relationship.

Formerly families were held together in spite of conflicts by external pressures of law, religion, and society. To-day these outer forces have begun to lose their effectiveness. Men and women can now separate without loss of status within the community or the family group. Marital stability depends,

therefore, more on the cohesive power of an inner unity and harmony than on the adhesive forces of social pressure.

Infidelity is another threat to marriage. In the past, infidelity in husbands was tacitly accepted, and a wife, if she found out about it, merely had to wait until the affair blew over. But the women of to-day, now that the old fears of infection and conception no longer hold, may also be tempted by the adventure of an extramarital affair. This adds another difficulty to maintaining a stable, permanent family unit.

These changes in values and attitudes have come about relatively fast; they have not as yet infiltrated sufficiently into the pattern of family living. At present we are still in a stage of transition. Each new generation has to improvise its behavior instead of being able to lean on tested experiences. We have severed our moorings to the old and have not yet anchored to the new. This makes for much tossing about of family life.

Marriage is a dynamic relationship. It requires continual adjustments as the family begins, as it expands with the coming of children, and as it contracts when the children later leave to establish their own family units. Some of the dissatisfactions in marriage emerge in later life, among the older people, particularly when they have failed to make a satisfactory mutual adjustment earlier in their relationship and have remained together only because the children were at home.

These observations on the dynamics and the pathology of marriage are based on a psycho-bio-social orientation. They represent the viewpoint of the physician who treats the individual as a total person, as an integrated being with a body, a mind, and emotions, which interact and influence one another. This is the point of view of social medicine, which recognizes that man cannot be treated in isolation, but that he brings with him problems of his relationships with his family, his work, and his total social environment.

To summarize then:

1. Men and women marry to satisfy three basic needs—the need for love, sex, and parenthood; the need for the security

of affection, for sexual satisfaction, and for the fulfillment of the desire for parenthood.

2. The numerous adjustments that are necessary in the marital relation result partly from constitutional biological differences and partly from the differences in the psychological and emotional equipment that men and women bring to marriage.

3. Cultural and social conditions and patterns of life influence materially both the biological and the psychological factors, and hence play an important rôle in marital adjustment.

4. Normal adjustments in marriage are made more difficult when there is pathology either in the biological or in the psychological make-up in one or the other mate, or in the social environment in which the couple lives.

THE HALFWAY HOUSE

THE RÔLE OF LAYMEN'S ORGANIZATIONS IN THE REHABILITATION OF THE MENTALLY ILL

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COMPROMISE and halfway measures seem to occupy a place of supreme importance in the psyche, for they are constantly brought to bear to maintain satisfactory equilibrium between what is inwardly desired and what is available in the outside world. When the struggle between inner and outer realities goes badly, symptoms of illness appear, and the patient comes to the psychiatrist for help. But the latter has a much more complicated task to perform than the mere recognition and naming of symptoms. He must proceed to estimate not only the severity of the disease, but also the strength of his patient's tendency to regain stable equilibrium and the conditions under which it can best be achieved.

The mental hospital, with its emphasis on illness and psychopathology, is admirably equipped for the study and care of the sick, but for those with potentialities for healthy living it can, as Eugen Bleuler taught long ago, foster morbid dependency and have an adverse effect. A halfway house, on the other hand, emphasizing health rather than disease, might offer a certain class of patients, not sick enough for the hospital or well enough to go home, an optimum environment for testing and realizing potentialities for health.

Years ago, Sir Thomas Clifford Allbutt, Regius Professor of Physic in the University of Cambridge, wrote that "all efforts to define diseases fully are in vain"; and elsewhere he said: "To know disease, then, we must first know the latitudes of health."¹ Very recently, the psychoanalyst, K. R. Eissler, expressed essentially the same idea when he said that the crucial question is not the symptomatology, but rather the reaction of the ego to the illness.²

¹ See his "Introduction" to *A System of Medicine*. Vol. I, p. xxxii and p. xxiii.

² See "The Effect of the Structure of the Ego on Psychoanalytic Technique," by E. K. Eissler. *Journal of the American Psychoanalytic Association*, Vol. 1, pp. 104-43, January, 1953.

Institutional psychiatrists have long been familiar with a group of patients whose progress in the mental hospital is at a standstill and whose continued hospitalization fosters dependency, loss of initiative, and neglect of potentialities for healthy living. Patients in this group present paradoxical features. They are able to maintain equilibrium in the hospital, but cannot do so at home. They recognize their need to escape from the stresses of the outside world, but in the hospital they avoid and resist attempts to help them resolve basic conflicts. They take flight from home to the hospital, and in the hospital they occupy a position midway between sickness and health. Treated as invalids, they profess health; assumed to be well, they soon demonstrate inability to withstand the stresses of the outside world.

Patients of this type are found in the various categories of official psychiatric nomenclature; some are called severe psychoneurotics, others are labeled schizophrenics, while still others are called psychopaths. The psychiatric diagnosis alone does not define them. Some have received shock therapy, and others have been given prolonged psychotherapy. A few have been subjected to every type of treatment known to modern psychiatrists. In spite of all this more or less expensive treatment, they have not shown sufficient improvement for discharge, and in consequence are allowed to settle into the routine of hospital life and into chronic illness.

It is conceivable that some of them, if carefully selected, would do well in an environment in which the emphasis was placed on health rather than on disease. Such an environment, controlled by laymen instead of by doctors and nurses, and stripped as far as possible of reminders of ill health, might bring to bear positive and powerful suggestion, leading to increasing health and independence.

It is true that there have been many attempts on the part of laymen in the past to care for the mentally ill, the history of which is at least as old as the colony at Gheel. But for such an experiment to succeed, it should be placed on a basis as rational and scientific as our present knowledge permits. On the one hand, it does not seem reasonable that laymen should undertake the care of the mentally ill without psy-

chiatic advice and guidance, or, on the other, that the psychiatrist, because he has not effected a cure, should indubitably believe that nothing more can be done. It seems logical to think that an environment intermediate between the mental hospital and the outside world—a "halfway house"—would make an important contribution to the rehabilitation of properly selected patients.

The ideal "halfway house" would not pretend to help all types of patient, but only those whose psychological needs could best be met in the environment it provides. Operated by laymen, it would recognize, nevertheless, the necessity of working in liaison with psychiatrists, particularly depending on them for the initial screening of its guests and for psychiatric advice if all does not go well. In this respect, it would differ significantly from those laymen's ventures with little or no professional guidance and counsel. But at the same time it would preserve in its everyday operations freedom from professional paternalism and interference and from the atmosphere of the psychiatric clinic.

At the "halfway house," the assumption would be that the former patient can function in a constructive, useful way; he would not only be able to play hard, but to work hard and well. If he made a steady, useful contribution of work, he would receive remuneration for it, just as he did before he became ill. He would be given an important share of responsibility for the administration and operation of the community, where, however, he would meet with more human understanding and tolerance than is ordinarily met in the world to which it is hoped he can eventually return, after regaining health and confidence during this intermediate phase. Having moved from the restricted and dependent existence of the mental hospital to the more independent, but still relatively simple, rural or even urban life at "halfway house," he would logically be better prepared to take his place in his own community again.

Like all hypotheses, this one of the advantages of a "halfway house" is meaningless unless it is adequately tested. For about twenty years, the idea has been applied at the Spring Lake Ranch at Cuttingsville, Vermont, in coöperation with

ew England psychiatrists. During that time, hundreds of patients have sojourned there, and judged by ordinary standards, the ranch has been relatively successful.

But those who conceived the idea are not satisfied with generalities. They ask themselves why, in the face of over-crowding in mental hospitals, their halfway house has not been more widely duplicated elsewhere. Anxious to establish their work on a firm scientific basis, they invite psychiatrists and clinical psychologists to conduct researches, and they express willingness to function as a training center for other interested laymen with special aptitude for this type of work, provided that those who are most qualified to judge and who seriously examine and evaluate their work believe it to be sound.

Whether the Spring Lake Ranch type of "halfway house" or some modification of it best meets the needs of the class of patients discussed above remains to be determined, since the idea is still in the process of development. But the search for new methods of rehabilitating the mentally ill demands a union of psychiatrists and of laymen unceasing interest and cooperation. The task remains complex and difficult in spite of great advances in theoretical medical psychology that have come with the dawn of the present century.

It seems certain, however, that if the mentally ill are to be colored to usefulness, an approach that is humane and constructive yields better results than one colored by apathy or pessimism. Patients of all types can be counted on to respond to some degree to those who show genuine interest and helpfulness, whether laymen or doctors. Where the need is great and the laborers so few, laymen's organizations modeled along lines that seek to define what Allbutt called the "latitudes of health" might well be considered as adjuncts to semi-hospital care, for it is in this field that the idea of the "halfway house" seems to offer the greatest contribution and, if executed with caution and wisdom, the most intriguing possibilities for favorable results.

RATES OF DISCHARGE AND RATES OF MORTALITY AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS *

THIRD PAPER

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THE New York State Department of Mental Hygiene adopted a new statistical system as of April 1, 1943. A punched card, with a wide variety of statistical information, was prepared for every patient on the books of the state and licensed mental hospitals on that date. Such punched cards have been prepared for every patient admitted thereafter. Corresponding punched cards have been prepared for the patients who were discharged or who died. Punched cards for the same patient are brought together in a permanent file, and enable one to make systematic studies of the hospital histories of the patients.

Two such studies have been made. The first was based upon the histories of first admissions to the New York civil state hospitals during the fiscal year that ended March 31, 1944;¹ the second, upon first admissions during the year that ended March 31, 1945.² When the data were made available for these analyses, the statistical files were complete through March 31, 1949. This date, therefore, marked the terminal point for the follow-up of these hospital histories. From among the first admissions to the civil state hospitals, those patients were selected for study who had not been transferred to or

* This investigation was supported by a research grant from the National Institute of Mental Health, of the National Institutes of Health, United States Public Health Service.

¹ See "Rates of Discharge and Rates of Mortality Among First Admissions to the New York Civil State Hospitals," by Benjamin Malzberg. *MENTAL HYGIENE*, Vol. 36, pp. 104-20, January, 1952.

² See "Rates of Discharge and Rates of Mortality Among First Admissions to the New York Civil State Hospitals: Second Paper," by Benjamin Malzberg. *MENTAL HYGIENE*, Vol. 36, pp. 618-38, October, 1952.

readmitted to another mental hospital, outside of the New York state-hospital system.

The present study is based upon a group of first admissions during the fiscal year that ended March 31, 1946. A patient admitted on the first day of the year (April 1, 1945) could therefore be followed for a period of four years, through March 31, 1949. A patient admitted on the last day of the fiscal year could be followed for only three years. In order to maintain the same maximum period of exposure¹ for each patient, it was therefore necessary to follow each patient for a maximum of three years from the date of admission. The patients included in this third follow-up study totaled 12,480, of whom 5,765 were males and 6,715, females.

As in the preceding studies, the duration of treatment was measured from the date of admission to the date of removal from the books. In some studies, the duration has been measured from the date of admission to the date of placement in convalescent care (parole).² I have preferred the former interval for reasons that appear to me to be substantial. In the first place, convalescent care (parole) need not imply the end of treatment. Psychotherapy is administered on an outpatient basis, and medical treatment in the form of shock therapy is becoming a part of the therapeutic process during the parole period. Furthermore, the duration of the interval prior to parole depends to a high degree upon the attitude of hospital administrators. Patients may have a shorter or longer residence, depending upon such attitudes. That this is not inconsequential may be seen from the fact that whereas 70 per cent of the patients are discharged by the New York civil state hospitals while in convalescent care, this percentage varies among the several hospitals from a minimum of 30 to a maximum of 85. Obviously, patients discharged by the latter hospital tend to have a shorter hospital residence than patients discharged by the former. There may be many factors, in addition to the condition of the patient, that determine placement in convalescent care.

Furthermore, instead of asking how many patients were

¹ An annual exposure is the equivalent of one person at risk of death for a year.

² See, for example, "New Facts on Prognosis in Mental Disease," by Robert H. Israel and Nelson A. Johnson. *American Journal of Psychiatry*, Vol. 104, pp. 540-45, March, 1948.

paroled or discharged within a specified period, one might ask how many were still in the hospital (or on the books) at the end of such period. From 30 to 40 per cent of the patients placed in convalescent care are subsequently returned to the hospital because of a continuation or an exacerbation of the same illness. A patient placed on parole during a month may be back in the hospital at the end of the month. Therefore, cohort studies based upon time intervals up to parole are not comparable to tables of life expectancies, since the date of parole is not a necessarily true terminal point with respect to the duration of the disease.

However, though the interval from admission to the hospital to discharge from the books is a better measure of duration, it is, nevertheless, imperfect in an important respect. Patients may be discharged in an automatic manner at the end of a maximum period of convalescence, the date being set in advance. In such cases, the true duration may be overstated by several months. It would appear that patients should be discharged from convalescent care when their condition determines the desirability of discharge. This should be the goal, thus making convalescent care an effective medical and social procedure. As this end is approached, the unit of time in measuring the duration of a mental disease after admission to a hospital will move closer and closer to a truer estimate.

Of the 5,765 male first admissions included in this study, 2,283, or 39.6 per cent, were discharged within three years after admission. (See Table 1.) As in the preceding studies, almost a quarter (24.3 per cent) were discharged within three months after admission. The number of discharges decreased rapidly during the rest of the first year. The discharges during the first year numbered 802, or 35.1 per cent of the total discharges. A little more than half of the discharges occurred during the second year after admission, as a result of the termination of periods of convalescent care.

The rate of discharge was greatest during the first three months, when there were 422.8 discharges per 1,000 annual exposures. The rate decreased rapidly during the remainder of the first year, so that the average rate for the year was only 161.8 per 1,000 exposures. Because of the termination

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TABLE 1. PATIENTS REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges		Deaths		Rate per 1,000 exposures *	Rate per 1,000 exposures *	Rate per 1,000 exposures *			
	Males		Females							
	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *						
First three months	555	422.8	480	310.0	1,038	752.8	1,042			
Second three months.....	125	123.6	144	114.0	273	265.6	288			
Third three months.....	73	79.2	77	66.0	172	184.0	177			
Fourth three months.....	49	66.4	58	52.4	137	156.0	151			
First year	802	161.8	759	129.0	1,615	301.1	1,658			
Second year	1,249	390.7	1,761	428.1	302	117.4	369			
Third year	232	185.1	252	121.1	159	94.6	175			
Total	2,283	.....	2,772	.....	2,076	.....	2,202

* On an annual basis.

of the period of convalescent care, the rate rose during the second year after admission, when it reached 390.7. The rate declined to 135.1 during the third year.

There were 6,715 female first admissions, of whom 2,772, or 41.3 per cent, were discharged within three years after admission. (See Table 1.) Of the total discharges, 480, or 17.3 per cent, occurred within the first three months after admission. As with the males, there was a rapid reduction in the number of discharges during the remainder of the first year. There were 759 discharges during the whole of the first year, or 27.4 per cent of the total discharges. Almost two-thirds of the discharges occurred during the second year. The discharge rate was 310.0 per 1,000 annual exposures during the first three months. The rate fell rapidly during the remainder of the first year, and averaged 129.0 per 1,000 annual exposures during the first year. It rose to 428.1 during the second year, and fell to 121.1 during the third year.

Of the 12,480 first admissions, 1,856, or 14.9 per cent, were discharged as recovered. (See Table 2.) An additional 1,638, or 13.1 per cent, were discharged as much improved. A total of 4,575, or 36.7 per cent, showed some degree of improvement at time of discharge. The sex differences in rates of improvement were not significant.

These rates of recovery and improvement may be compared with a follow-up of first admissions to the New York civil state hospitals between 1909 and 1913.¹ The hospital histories of these patients were followed for 15 years from the date of admission. For purposes of comparison, we may consider the condition of these patients at the end of three years after admission.

The rate of recovery was 20.8 per cent, and the total rate of improvement was 37.5 per cent. The rate of recovery was higher than that found in the present study, but the total rates of improvement were on a par. Since it is frequently difficult to distinguish between grades of recovery and of much improvement, part of the difference with respect to rates of recovery may be ascribed to this factor. A more important factor, however, is the much greater prevalence

¹ See "Hospital Departures and Readmissions Among Mental Patients During the Fifteen Years Following First Admission," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, pp. 642-74, October, 1930.

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TABLE 2. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION,
CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Males		Females		Total	
	Number	Per cent of total discharges	Number	Per cent of total discharges	Number	Per cent of total discharges admissions
Recovered	755	33.1	1,102	39.8	1,856	36.7
Much improved	745	32.6	893	32.2	1,638	32.4
Improved	513	22.5	568	20.5	1,081	21.4
Unimproved	176	7.7	184	6.6	360	7.1
Without psychosis	94	4.1	16	0.9	0.4	2.9
Total discharges	2,283	100.0	2,772	100.0	5,055	100.0
Total first admissions *	5,765	....	6,715	....	12,480	....

* Number of first admissions during the year ended March 31, 1946.

to-day of senile psychoses and psychoses with cerebral arteriosclerosis, both of these groups having low rates of recovery and of improvement in general. In 1910, these two groups included only 14 per cent of the total first admissions, compared with 38 per cent in 1946. Because of the excess in recent years, the rate of improvement is weighted downwards. Therefore, more detailed comparisons will be made in later sections with respect to comparable groups of mental disorders.

Of the 5,765 male first admissions, 2,076, or 36.0 per cent, died within three years after admission. (See Table 1.) Half of the deaths occurred within three months after admission. The number of deaths decreased rapidly during the remainder of the first year, but by the end of that period totaled 1,615, or 77.8 per cent of the total deaths. The death rate was 752.8 per 1,000 annual exposures during the first quarter of the first year. The average death rate during the first year was 301.1. The death rate fell to 94.6 during the third year.

Of the 6,715 female first admissions, 2,202, or 32.8 per cent, died within the period of three years after admission. (See Table 1.) As in the case of the males, almost half of the deaths occurred within three months after admission, and three-fourths occurred during the first year. The death rate was 643.6 per 1,000 annual exposures during the first three months, but fell to 134.8 during the last three months of the year. The average death rate was 261.7 during the first year after admission. The death rate decreased among those with longer hospital residences. As usual, females had lower death rates than males.

Table 3 shows the number of the first admissions on the books of the New York civil state hospitals at stated periods after admission. Account has been taken of patients who were readmitted after discharge. Within three months after admission, the number of male patients was reduced from 5,765 to 4,219, or to 73.2 per cent of the total. By the end of the first year there were 3,478 still on the books, or 59.3 per cent. In a little more than one year, the total was reduced by 50 per cent. At the end of the third year, only 1,572, or 27.3 per cent, were still on the books.

Because of their lower discharge and death rates, higher

proportions of females than of males were on the books at the end of corresponding intervals. Of the 6,715 female first admissions, 78.1 per cent were on the books at the end of three months, 66.9 per cent at the end of a year, and 30.0 per cent at the end of three years.

As in preceding studies in this series, we shall study rates of discharge and of mortality in several groups of mental disorders. This is necessary, since these rates vary significantly from group to group, and without such comparisons the differences would be concealed by the average results shown by the whole group of first admissions. For

TABLE 3. NUMBER OF PATIENTS REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

End of period	Males		Females	
	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	4,219	73.2	5,244	78.1
Sixth month	3,848	66.7	4,864	72.4
Ninth month	3,638	63.1	4,660	69.4
First year	3,478	59.3	4,492	66.9
Second year	1,943	33.7	2,400	35.7
Third year	1,572	27.3	2,013	30.0

such comparisons, we shall select groups that are of importance, either numerically or clinically.

Psychoses with Cerebral Arteriosclerosis.—There has been a remarkable increase in the number of first admissions with psychoses with cerebral arteriosclerosis. Forty years ago they numbered less than 200 annually, and included only 3 per cent of all first admissions. To-day there are more than 3,000 such first admissions annually, and they represent 20 per cent of the total first admissions. As they have low discharge rates and high death rates, this group exerts an unfavorable influence with respect to the average rates of discharge and mortality for the entire group of first admissions.

There were 1,380 male first admissions with psychoses with cerebral arteriosclerosis. (See Table 4.) Of this total, only 210, or 15.2 per cent, were discharged within three years after admission, compared with 39.6 per cent of all male first admissions. A fourth of the discharges occurred within three,

TABLE 4. PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOCLEROSIS REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharge		Deaths		Females		Males		Females	
		Rate per 1,000 exposures *		Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *
First three months	51	178.4	40	135.2	472	(1000.0)	408	(1000.0)	408	(1000.0)
Second three months	7	35.2	8	36.0	123	576.4	112	478.0	112	478.0
Third three months	4	23.2	6	30.4	69	380.8	72	352.0	72	352.0
Fourth three months	5	32.0	7	39.6	63	386.8	69	373.2	69	373.2
First year	67	65.9	61	57.6	727	539.9	661	486.6	661	486.6
Second year	128	246.2	144	242.8	132	252.9	148	248.7	148	248.7
Third year	15	102.4	15	43.9	66	207.2	67	182.3	67	182.3
Total	210	.....	220	.....	925	.....	876	.....	876	.....

* On an annual basis.

months after admission, representing an annual discharge rate of 178.4 per 1,000 exposures. There were few discharges during the remainder of the first year, the average rate for the first year being only 65.9 per 1,000 annual exposures. There were 128 discharges during the second year, or a rate of 246.2, but the rate dropped to 102.4 during the third year.

Among the 1,389 female first admissions with psychoses with cerebral arteriosclerosis, there were 220 discharges within the period of three years, or 15.8 per cent. There were few discharges during the first year after admission, most of these occurring during the first three months. During this period there was a discharge rate of 135.2 per 1,000 annual exposures. The average discharge rate during the first year was 57.6. The rate rose to 242.8 during the second year after admission, but fell to 43.9 during the third year.

Compared with the results for the corresponding group of first admissions in 1910-1913, the present results are unfavorable. Among males, the percentage of discharges within three years after admission declined from 26.7 to 15.2. Among females, they declined from 21.5 to 15.8.

The recovery rate was low. Of the 2,769 first admissions with psychoses with cerebral arteriosclerosis, only 90, or 3.3 per cent, were reported as recovered within the three years after admission. (See Table 5.) The total rate of improvement was 14.0 per cent. There was no significant difference with respect to sex.

Four decades ago, the recovery rate among first admissions with psychoses with cerebral arteriosclerosis within three years after admission was 5.2 per cent, and the total rate of improvement was 21.9 per cent. It appears that the rate of improvement in this group has declined.

Death rates are high among first admissions with psychoses with cerebral arteriosclerosis. Of the 1,380 males, 925, or 67.0 per cent, died during the three years after admission. (See Table 4.) Half of the deaths occurred during the first three months after admission. Three-fourths occurred during the first year. Had the rate during the first three months continued, all would have died within nine months. The rate dropped, however, the average for the first year after admis-

TABLE 5. DISCHARGES AMONG FIRST ADMISSIONS WITH PSYCHOSIS WITH CEREBRAL ARTERIOSCLEROSIS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Number	Males		Females		Number	Per cent of first discharges admissions	Per cent of total discharges	Per cent of first discharges admissions	Per cent of total of first discharges admissions	Per cent of total of first discharges admissions
		Per cent of total discharges	Per cent of first discharges admissions	Per cent of total discharges	Per cent of first discharges admissions						
Recovered	41	19.5	3.0	49	22.3	3.5	90	20.9	3.3		
Much improved	79	37.6	5.7	82	37.3	5.9	161	37.4	5.8		
Improved	69	32.9	5.0	68	30.9	4.9	137	31.9	4.9		
Unimproved	21	10.0	1.5	21	9.5	1.6	42	9.8	1.5		
Total discharges	210	100.0	15.2	220	100.0	15.8	430	100.0	15.5		
Total first admissions *	1,380	....	100.0	1,389	....	100.0	2,769	....	100.0		

* Number of first admissions with psychoses with cerebral arteriosclerosis during the year ended March 31, 1946.

sion being 539.9 per 1,000 annual exposures. The death rate fell to 207.2 during the third year.

Females showed a similar trend, though the death rates were lower than among males. Of the 1,389 female first admissions, 876, or 63.1 per cent, died during the three years after admission. Three-fourths of the deaths occurred during the first year, during which time the first three months showed the heaviest mortality. The average death rate for the first year was 486.6 per 1,000 annual exposures. The rate fell to 182.3 during the third year.

The experience of four decades ago indicates that 61.5 per cent of such patients died within three years after admission, compared with 65.0 per cent in the present study. The excess is not great, but when considered in correlation with corresponding differences in rates of discharge and of improvement, there is an implication that the expectations of discharge and of improvement are not as good as they used to be among this group of patients. This cannot be ascribed to methods of treatment, and it is, therefore, probable that the increasing rate of first admissions with psychoses with cerebral arteriosclerosis is associated with a poorer physical selection of individuals who rise to the age levels associated with these disorders.

Senile Psychoses.—First admissions with senile psychoses have been increasing in number. They have low discharge rates and high mortality rates, so that, as with psychoses with cerebral arteriosclerosis, they affect the average results for all patients in an unfavorable manner. There were 840 such male first admissions included in this analysis, of whom only 45, or 5.4 per cent, were discharged within three years after admission. (See Table 6.) A third of the discharges occurred during the first year. Half occurred during the second year. The discharge rate per 1,000 annual exposures fell from 200.0 during the three months following admission to 14.3 during the last quarter, with an average of 27.2 for the entire first year. These rates are less than half of the corresponding rates among first admissions with psychoses with cerebral arteriosclerosis.

Of the 1,326 female first admissions with senile psychoses, 80, or 6.0 per cent, were discharged within three years. In

TABLE 6. PATIENTS WITH SENTIEN PSYCHOSES REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges			Deaths		
	Males		Females	Males		Females
	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *
First three months	10	200.0	25	238.1	320	(1000.0)
Second three months	8	35.1	4	28.1	84	666.7
Third three months	2	26.4	1	7.3	60	572.8
Fourth three months	1	14.3	3	24.2	40	445.7
First year	16	27.2	33	34.4	504	605.8
Second year	25	91.4	40	84.3	93	502.4
Third year	4	22.5	7	22.0	49	245.0
Total	45	.....	80	.....	646	.....
						968

* On an annual basis.

general, they had a higher rate of discharge than the males. The rate of discharge per 1,000 annual exposures fell from 238.1 during the first three months after admission to 7.3 during the third quarter of the year, with an average of 34.4 during the first year. The rate rose to 84.3 during the second year, and fell to 22.0 during the third year.

These discharge rates are significantly less than the rates experienced forty years earlier.

The recovery rate for these patients was only 1.0 per cent during the three years after admission. (See Table 7.) The total rate of improvement was 4.8 per cent. These are considerably less than the corresponding rates for the arteriosclerotic group.

Forty years ago the recovery rate among first admissions with senile psychoses was 1.3 per cent, and the total rate of improvement was 9.8 per cent. These exceed the corresponding rates for the present group of first admissions. As in the case of the arteriosclerotics, there is a suggestion that patients admitted with senile disorders are not as good a physical selection among the aged as those admitted from an earlier generation.

As the question of the differentiation of senile psychoses and psychoses with cerebral arteriosclerosis is frequently raised, we may make a further comparison by combining the two groups of first admissions for each period. (See Table 8.) On this basis, the rate of recovery for the group admitted in 1945-1946 was 2.0 per cent, compared with 3.3 per cent for the earlier period. The total rates of improvement were 9.1 and 15.0 per cent, respectively. This confirms the results found separately for each of these groups of psychoses.

Mortality rates are high. Of the 840 male first admissions with senile psychoses, 646, or 76.9 per cent, died within three years after admission. (See Table 6.) Half of the deaths occurred within three months after admission. Had this rate continued, the male patients would all have died in about seven months. The death rate decreased, however, so that 504 died during the first year, corresponding to an annual rate of 605.8 per 1,000 exposures. During the third year, the death rate dropped to 245.0.

Of the 1,326 female first admissions, 968, or 73.0 per cent,

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TABLE 7. DISCHARGES AMONG FIRST ADMISSIONS WITH SENILE PSYCHOSES TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Males	Females				Total
		Per cent of total discharges	Per cent of first admissions	Number	Per cent of total discharges	
Recovered	3	6.7	0.4	18	22.5	1.4
Much improved	13	28.9	1.5	13	16.3	1.0
Improved	21	46.7	2.5	36	45.0	2.7
Unimproved	8	17.7	1.0	13	16.3	1.0
Total discharges	45	100.0	5.4	80	100.0	6.0
Total first admissions*	840	.....	.....	1,326	.....	.....
						2,166

* Number of first admissions with senile psychoses during the year ended March 31, 1946.

TABLE 8. DISCHARGES AMONG FIRST ADMISSIONS WITH SENILE PSYCHOSES AND PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Males	Females				Total
		Per cent of total discharges	Per cent of first admissions	Number	Per cent of total discharges	
Recovered	44	17.3	2.0	70	20.3	2.0
Much improved	92	36.1	4.1	108	31.3	3.0
Improved	90	35.3	4.1	125	36.2	3.5
Unimproved	29	11.4	1.3	42	12.2	1.2
Total discharges	255	100.0	11.4	345	100.0	9.7
Total first admissions*	2,220	.....	.....	3,554	.....	5,775
					

* Number of first admissions with senile psychoses and psychoses with cerebral arteriosclerosis during the year ended March 31, 1946.

died within three years after admission. Of the total deaths, 453, or 46.8 per cent, occurred within three months. Seventy-six per cent occurred during the first year. The annual death rate was 562.0 per 1,000 exposures during the first year after admission, with a reduction to 192.3 during the third year.

As with first admissions with psychoses with cerebral arteriosclerosis, there has been an increased rate of mortality among those with senile psychoses in recent years. Thus 76.9 per cent of the present group of males died within three years after admission, compared with 70.3 per cent of a similar group admitted 40 years ago. Among females, the corresponding percentages were 73.0 and 62.7, respectively. For both sexes, combined, the rates were 74.5 and 66.5 per cent, respectively. Since a larger proportion of the general population is reaching old age, these comparisons raise the question of the possible effect of adverse natural selection among the contemporary elderly groups.

General Paresis.—Up to 1920 first admissions with general paresis represented 13 per cent of the total annual first admissions to the New York civil state hospitals. Since 1920 they have represented a steadily declining proportion, until to-day they include less than 3 per cent. The actual number of such first admissions has declined, despite the fact that the general population has increased by several millions. Since 1920, the treatment of general paresis has undergone a revolutionary change. It is, therefore, of importance to see what has been the effect with respect to rates of discharge and mortality.

Of 433 male first admissions with general paresis in 1945-1946, 126, or 29.1 per cent, were discharged within three years after admission. (See Table 9.) The corresponding rate in the control study was 20.0 per cent. Of the 126 discharges, only 21, or 16.7 per cent, occurred during the first year after admission. Two-thirds occurred during the second year. The discharge rate was 58.3 per 1,000 annual exposures during the first year. It rose to 334.0 during the second year. The rate was 142.4 during the third year, which nevertheless was in marked excess over the rate during the first year.

Of the 134 female first admissions with general paresis, 46, or 34.3 per cent, were discharged within three years, com-

TABLE 9. PATIENTS WITH GENERAL PARESIS REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges			Deaths		
	Males		Females	Males		Females
	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *
First three months	9	136.9	5	208.3	85	819.3
Second three months	5	71.7	3	122.4	30	364.7
Third three months	3	43.8	1	41.2	15	201.3
Fourth three months	4	63.0	1	41.7	16	230.2
First year	21	58.3	10	88.3	146	345.6
Second year	84	334.0	29	311.8	29	129.4
Third year	21	142.4	7	120.7	11	77.2
Total	126	.....	46	.....	186	.....
					40	.....

* On an annual basis.

pared with only 25.2 per cent among a similar group admitted four decades ago. It is evident, therefore, that there has been an increase in the discharge rate. Of the 46 discharges, the great majority occurred during the second year after admission. The annual discharge rate rose from 83.3 per 1,000 exposures during the first year to 311.8 during the second year. The rate fell during the third year, but remained in excess of the discharge rate for the first year.

The condition at discharge is shown in Table 10. Those discharged as recovered totaled 27, or 4.8 per cent of the total admissions. Those discharged as either recovered or improved included 28.4 per cent of the total admissions. These may be compared with the corresponding percentages during the earlier period. Of the latter group, only 0.6 per cent were discharged as recovered, and only 14.1 per cent showed some degree of improvement. Here is clear proof of the value of the new methods of chemo-therapy.

Increases in rates of improvement have been accompanied by important reductions in mortality. Of the male first admissions with general paresis in 1910-1913, 70.5 per cent died within three years. Of the corresponding group in 1946, only 29.1 per cent died within three years. Among females, the percentages were 34.3 in 1946 and 55.7 per cent in 1910.

Of the 186 deaths among male general paretics in 1945-1946, 146, or 78.5 per cent, occurred during the first year after admission. (See Table 9.) Almost half occurred within three months after admission. The death rate during the latter period was 819.3 per 1,000 annual exposures. The death rate decreased as the period of hospitalization increased. The average rate during the first year was 345.6. It decreased rapidly to 77.2 during the third year.

As in the case of the males, the crucial period among females was the first three months after admission. Half of the female deaths occurred during this period, representing an annual rate of 612.9 per 1,000 annual exposures. The death rate decreased rapidly after this period. The average for the first year was 217.1. Males had higher death rates than females.

Alcoholic Psychoses.—Of 514 male first admissions with alcoholic psychoses, 301, or 58.6 per cent, were discharged,

TABLE 10. DISCHARGES AMONG FIRST ADMISSIONS WITH GENERAL PARESIS TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Number	Males		Females		Total		
		Per cent of total discharges	Per cent of first admissions	Number	Per cent of total discharges	Per cent of first admissions	Number	Per cent of total discharges
Recovered	20	15.9	4.6	7	15.2	5.2	27	15.7
Much improved	63	50.0	14.5	20	43.4	14.9	83	48.3
Improved	34	27.0	7.9	17	37.0	12.7	51	29.7
Unimproved	9	7.1	2.1	2	4.3	1.4	11	6.4
Total discharges	126	100.0	29.1	46	100.0	34.3	172	100.0
Total first admissions*	433	.....	.....	134	.....	.....	567	.....

* Number of first admissions with general paresis during the year ended March 31, 1946.

within three years after admission. (See Table 11.) Of the total discharges, 106, or 35.2 per cent, occurred within the first three months. Very few were discharged during the remainder of the first year, the total for this period being 126. Almost half were discharged during the second year. The rate of discharges per 1,000 annual exposures was 902.1 during the first three months. The rate decreased rapidly, so that the average for the first year was 253.8. The maximum rate, 417.9, occurred during the second year.

There were 140 female first admissions with alcoholic psychoses, of whom 87, or 62.1 per cent, were discharged during the three years after admission. Only 16 discharges occurred during the first year, of which 13 took place within three months after admission. Almost three-fourths occurred during the second year. The discharge rate fell from 406.3 per 1,000 annual exposures during the first three months to 69.0 during the last quarter of the year, the average for the first year being 118.1. The rate rose to 552.6 during the second year, and fell to 163.3 during the last year. It is noteworthy that females had longer hospital durations than males.

Among first admissions of an earlier date, (1910-1913), 73.2 per cent of the males were discharged within three years, significantly in excess of the rate for the present group. The rate for the females differed only slightly, 58.0 per cent of the earlier group having been discharged within three years, as compared with 62.1 per cent of the later group.

Of the 654 first admissions with alcoholic psychoses, 248, or 37.9 per cent, were recovered. (See Table 12.) Including all who showed some degree of improvement, the percentage was 58.5. Males showed a slight excess over females with respect to the rate of improvement. Compared with an earlier group of first admissions with alcoholic psychoses, it appears that the recovery rate fell from 45.8 per cent in 1910 to 37.9 per cent in 1946. Improvement of all degrees fell from 62.9 per cent to 58.5. However, this comparison is probably spurious. The rate of recovery and improvement (as of discharge in general) depends upon the age at admission. Under forty years of age, such rates are over 80 per cent. At older ages, they drop to less than 40 per cent. Of the first admissions with alcoholic psychoses to the New York

TABLE II. PATIENTS WITH ALCOHOLIC PSYCHOSES REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges				Deaths			
	Males		Females		Males		Females	
	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *	Number	Rate per 1,000 exposures *
First three months	106	902.1	13	406.3	22	291.4	6	210.5
Second three months	13	139.8	1	336.1	7	77.8	1	33.6
Third three months	4	44.7	....	....	4	44.7	1	33.6
Fourth three months	3	33.9	2	69.0	2	22.7	1	35.1
First year	126	253.8	16	118.1	35	77.6	9	68.2
Second year	145	417.9	63	552.6	12	42.8	2	24.0
Third year	30	157.1	8	163.3	10	65.2	2	43.4
Total	301	....	87	....	57	....	13	....

* On an annual basis.

TABLE 12. DISCHARGES AMONG FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Males		Females		Total	
	Number	Per cent of total discharges	Number	Per cent of total discharges	Number	Per cent of total discharges
Recovered	197	65.4	38.3	51	58.6	36.4
Much improved	63	20.9	12.3	21	24.1	15.0
Improved	36	12.0	7.0	15	17.2	10.7
Unimproved	5	1.7	1.0	...	...	...
Total discharges	301	100.0	58.6	87	100.0	62.1
Total first admissions	514	....	....	140	....	....
					654	....

* Number of first admissions with alcoholic psychoses during the year ended March 31, 1946.

civil state hospitals in 1946, 43 per cent were aged fifty or over. Of those admitted in 1913, only 26 per cent were in this age group.

Unfortunately, the age distribution of the group of patients included in the earlier study is not available, with respect either to age at admission or to age at discharge, and it is, therefore, impossible to make the necessary age adjustments for purposes of comparison. It is evident, however, that this factor alone must have decreased the discharge rate during the later period.

We may consider next the mortality among the first admissions with alcoholic psychoses. Of the 514 males, 57, or 11.1 per cent, died within the three years after admission. (See Table 11.) Most of the deaths occurred during the first year, when there were 35 deaths, or 61.4 per cent of the total. The rate was 77.6 per 1,000 annual exposures. The rate fell to 42.8 during the second year, and to 55.2 during the third year.

Among the 140 females, there were 13 deaths within three years, or 9.3 per cent. Of the total deaths, 9 occurred during the first year, a rate of 68.2 per 1,000 exposures. The rate fell to 24.0 during the second year, and to 43.4 during the third year.

The percentage of males dying within three years after admission, 11.1, exceeded that of the corresponding group of male admissions in 1910, which was 9.5. Female admissions in 1910 had a corresponding percentage of 19.2, as compared with 9.3 in 1946. Thus, despite the disadvantages of a higher relative age distribution, the death rate of the male alcoholics did not differ significantly from that of the earlier period, and the death rate of the females was significantly lower. This is probably due to the improvements associated with advances in nutritional therapies.

Involutorial Psychoses.—First admissions with involutorial psychoses have shown an upward trend for several decades. It is, therefore, of importance to study the outcome of their hospital residences. Included in the present analysis are 244 male first admissions during the fiscal year 1945-46. Of this total, 157, or 64.3 per cent, were discharged within three years after their admission. (See Table 13.) There were very few discharges during the first year, such dis-

TABLE 13. PATIENTS WITH INVOLUNTARY PSYCHOSES REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges		Deaths		Females		Males		Females		Males	
First three months	15	272.7	48	356.9	12	224.3	31	246.1	5	39.4	6	24.4
Second three months	6	114.8	7	54.8	4	78.0	5	24.4	3	8.4	22	71.0
Third three months	1	19.4	9	71.6	2	38.4	1	29.3	1	8.4	120	29.3
Fourth three months . . . . .	....	....	9	73.4	4	77.3	40	24.2	4	24.2	157	54
First year	22	94.4	73	125.9	22	94.4	405	24.2	4	24.2	....	....
Second year	120	613.8	292	605.8	9	64.3	10	24.2	....	....	....	....
Third year	15	217.4	40	218.6	4	63.0	4	24.2	....	....	....	....
Total	157	....	405	....	35	....	....	....	....	....	....	....

* On an annual basis.

charges numbering only 22, or 14.0 per cent of the total discharges. Most of these, in turn, occurred within three months after admission. The great majority of the discharges occurred during the second year. The rate of discharges per 1,000 annual exposures was 272.7 during the first three months, but declined rapidly during the remainder of the first year, so that the average rate for the year was 94.4. The rate increased to 613.8 during the second year, and dropped to 217.4 during the third year. The latter was still in excess of the rate during the first year.

There were 600 female first admissions with involutional psychoses, of whom 405, or 67.5 per cent, were discharged within three years after admission. The sexes did not differ significantly in this respect. There were relatively few discharges during the first year. Of the total, 292, or 72.1 per cent, occurred during the second year. The discharge rate was 356.9 per 1,000 annual exposures during the three months after admission. The average rate for the first year was 125.9. The rate rose to a maximum of 605.8 during the second year, and decreased to 218.6 during the third year.

The condition of the patients at discharge is summarized in Table 14. Of the 844 first admissions, 303, or 35.9 per cent, were recovered. The much improved included 169, or 20.0 per cent. Those with all degrees of improvement included 65.3 per cent of the total admissions. There were no significant differences between the sexes with respect to rates of recovery or improvement. Because of the absence of comparable data, it is impossible to contrast the results with those of any earlier period.

Of the 244 male first admissions, 35, or 14.3 per cent, died within three years after admission. (See Table 13.) Most of the deaths occurred during the first year. Within this period, the highest mortality rate occurred during the first three months after admission. The average death rate per 1,000 annual exposures was 94.4 during the first year. The rate dropped rapidly after the first year, and was fairly constant during the later years.

Of the 600 female first admissions, 54, or 9.0 per cent, died during the three years after admission. This is significantly less than the corresponding rate for males. More than half

MENTAL HYGIENE

TABLE 14. DISCHARGES AMONG FIRST ADMISSIONS WITH INVOLUNTARY PSYCHOSES TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Males		Females		Total	
	Number	Per cent of total discharges	Number	Per cent of total discharges	Number	Per cent of total discharges
Recovered	85	54.1	218	53.8	303	53.9
Much improved	50	31.8	119	29.4	169	30.1
Improved	22	14.0	9.0	57	14.1	79
Unimproved .....	....	....	....	11	2.7	11
Total discharges	157	100.0	64.3	405	100.0	67.5
Total first admissions *	244	....	....	600	....	....
					844	....

* Number of first admissions with involuntary psychoses during year ended March 31, 1946.

of the deaths occurred within three months after admission, and three-fourths occurred during the first year. The rate per 1,000 annual exposures fell from 71.0 during the first year to 29.3 during the second year, and to 24.2 during the third year.

Manic-Depressive Psychoses.—There were 156 male first admissions with manic-depressive psychoses, during the fiscal year 1945-1946, who were included in the analysis. Of this total, 127, or 81.4 per cent, were discharged within three years after admission. (See Table 15.) This is less than the corresponding rate, 88.8 per cent, found four decades earlier. Forty discharges, or 31.4 per cent of the total, occurred during the first year, most of them during the first three months. Two-thirds of the discharges occurred during the second year. The rate of discharge per 1,000 annual exposures began with 783.8 during the first three months, averaged 262.3 during the first year, and rose to 745.3 during the second year.

Among the 333 female first admissions with manic-depressive psychoses, there were 268 discharges within three years following admission, or 80.4 per cent. This was on a par with the corresponding percentage, 81.2, which prevailed among an earlier group. Of the total discharges, 60, or 22.4 per cent, occurred during the first year after admission, and 189, or 70.5 per cent, during the second year. The rate per 1,000 annual exposures began with 577.0 during the first three months, decreased to an average of 185.4 during the first year, and rose to a maximum of 747.0 during the second year. On the whole, females had lower rates of discharge than males in corresponding intervals.

Of the 489 first admissions with manic-depressive psychoses, 234, or 47.9 per cent, were recovered within three years after admission. (See Table 16.) The total showing some degree of improvement was 383, or 78.3 per cent. The recovery rate was less than that reported for the group admitted during 1910-1913, but those described as much improved exceeded the corresponding earlier rate. The combined rate of improvement, 78.3 per cent, corresponded closely with a rate of 79.2 per cent reported four decades ago.

*Of the 156 male first admissions, 13, or 8.3 per cent, died

MENTAL HYGIENE

TABLE 15. PATIENTS WITH MANIC-DEPRESSIVE PSYCHOSES REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS,
CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges		Deaths		Females		Males		Females		Males	
First three months	29	783.8	44	577.0	4	163.3	14	228.6				
Second three months	7	233.3	11	163.6	3	110.1	3	47.4				
Third three months	4	141.6	2	30.9	...	...	1	15.6				
Fourth three months . . . . .	...	...	3	46.9	...	...	1	15.9				
First year	40	262.3	60	185.4	7	51.4	19	62.7				
Second year	79	745.3	189	747.0	6	86.3	2	12.5				
Third year	8	333.3	19	306.4	...	...	2	37.4				
Total	127	...	268	...	13	...	23	...				

* On an annual basis.

TABLE 16. DISCHARGES AMONG FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO THE NEW YORK CIVIL STATE HOSPITALS
WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Males		Females		Total	
	Number	Per cent of total discharges	Number	Per cent of total discharges	Number	Per cent of total discharges
Recovered	71	55.9	45.5	60.8	234	59.2
Much improved	43	33.9	27.6	24.3	108	27.3
Improved	12	9.4	7.7	10.8	41	10.4
Unimproved	1	0.8	0.6	4.1	3.3	8.0
Total discharges	127	100.0	81.4	100.0	395	100.0
Total first admissions *	156	....	333	....	489	....

* Number of first admissions with manic-depressive psychoses during the year ended March 31, 1946.

within three years after admission. Of the 333 female first admissions, 23, or 6.9 per cent, died within this period. Both are slightly less than the corresponding percentages for the earlier groups.

Seven of the thirteen male deaths occurred during the first year after admission. Because of the small number, no significant trend is apparent. Among the females, it is clear that there was a relatively heavy mortality during the first three months. Fourteen deaths, or 60.9 per cent of the total deaths, occurred during this period, representing a rate of 228.6 per 1,000 annual exposures. The rate fell during the remainder of the year and averaged 62.7 for that period. The death rate dropped rapidly after the first year.

Dementia Praecox.—Of the 1,218 male first admissions with dementia praecox, 738, or 60.6 per cent, were discharged within three years after admission. (See Table 17.) The rate of discharge was low during the first year, only 197, or 26.7 per cent of the total discharges, occurring during this period. The bulk of the discharges occurred during the second year. The rate of discharge was 314.4 per 1,000 annual exposures during the first three months after admission. The rate decreased rapidly during the remainder of the first year, and averaged 163.9 per 1,000 annual exposures during that period. The discharge rate grew to 457.2 during the second year after admission.

Of 1,962 female first admissions with dementia praecox, 1,149, or 58.6 per cent, were discharged within three years after admission. As in the case of the males, there were few discharges during the first year of residence, and of these about half occurred during the first three months. Sixty-five per cent of the discharges occurred during the second year after admission. The discharge rate was 280.8 per 1,000 annual exposures during the first three months. After a rapid reduction, the discharge rate averaged 144.9 during the first year. This was significantly less than the corresponding rate for the males. During the second year, however, the rate for females advanced to 614.3, which was significantly in excess of that of the males.

As compared with discharges of the earlier period, it may be noted that 60.6 per cent of the male admissions during

TABLE 17. PATIENTS WITH DEMENTIA PRÆCOX REMOVED FROM THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	Discharges		Deaths		Females		Males		Females		Males	
First three months.....	95	314.4	134	280.8	19	64.8	35	75.2				
Second three months.....	54	196.0	80	182.8	2	7.6	10	23.2				
Third three months.....	30	114.8	39	94.0	7	27.2	8	19.6				
Fourth three months.....	18	71.2	22	54.4	4	16.0	2	4.8				
First year.....	197	163.9	275	144.9	32	28.6	55	30.8				
Second year.....	451	457.2	750	614.8	5	6.5	16	10.1				
Third year.....	90	169.8	124	150.6	6	12.3	13	16.9				
Total.....	738	.....	1,149	.....	43	.....	84	.....			

* On an annual basis.

1945-46 resulted in discharge within three years, compared with 51.8 per cent of a group admitted four decades earlier. Among females, the corresponding percentages were 58.6 and 35.3, respectively. It is clear, therefore, that the discharge rate has increased significantly.

Of the 3,180 first admissions with dementia praecox in 1945-1946, 16.4 per cent were discharged as recovered, and 23.1 per cent as much improved. (See Table 18.) The total discharged within three years after admission with some degree of improvement was 53.5 per cent.

Compared with the data for the period 1910-1913, we find that rates of recovery within a period of three years after admission increased from 5.7 to 16.4 per cent; rates of much improvement increased from 8.7 to 23.1 per cent; and total rates of improvement increased from 29.1 to 53.5 per cent. Thus, not only are patients with dementia praecox discharged to-day at a higher rate, but their rates of recovery and of general improvement are also better. These admirable results must be attributed in large part to the development of the shock therapies.

However, because of difficulties in diagnosis, and fashions in diagnoses, there are some who feel that the results ascribed to patients with dementia praecox may, in fact, be due to the inclusion of patients who in earlier days might have been described as manic-depressives, among whom there is a high rate of spontaneous recovery. One way of testing this hypothesis is to combine the two groups, and to compute joint rates of discharge and of improvement. This is shown in Table 19. Of the 3,633 first admissions in 1945-1946 diagnosed as either manic-depressive or dementia praecox, 2,282, or 62.8 per cent, were discharged within three years after admission. This exceeds the corresponding percentage for dementia praecox alone. However, if a similar comparison is made by combining the rates for the earlier period, we obtain an average percentage of only 49.1.

Considering, in the same way, the condition of the patients at time of discharge, we find that the combined group had a recovery rate of 20.9 per cent, compared with 12.9 per cent for the earlier control group. Rates of much improvement were 23.2 and 8.7 respectively. All degrees of improvement

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TABLE 18. DISCHARGES AMONG FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Number	Males		Females		Total	
		Per cent of total discharges	Per cent of first discharges	Number	Per cent of total discharges	Per cent of first discharges	Number
Recovered	151	20.4	12.4	373	32.4	19.0	524
Much improved	295	40.0	24.2	440	38.3	22.4	735
Improved	206	27.9	16.9	239	20.8	12.2	445
Unimproved	86	11.7	7.1	97	8.4	4.9	183
Total discharges	738	100.0	60.6	1,149	100.0	58.6	1,887
Total first admissions*	1,218	...	100.0	1,962	...	100.0	3,180

* Number of first admissions with dementia praecox during the year ended March 31, 1940.

TABLE 19. DISCHARGES AMONG FIRST ADMISSIONS WITH DEMENTIA PRAECOX OR MANIC-DEPRESSIVE PSYCHOSES TO THE NEW YORK CIVIL HOSPITALS WITHIN THREE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	Number	Males		Females		Total		
		Per cent of total discharges	Per cent of first discharges	Number	Per cent of total discharges	Per cent of first discharges	Number	Per cent of total discharges
Recovered	222	25.7	16.2	536	37.8	23.7	758	33.2
Much improved	338	39.1	24.6	505	35.6	22.4	843	36.9
Improved	218	25.2	15.9	268	18.9	11.9	486	21.3
Unimproved	87	10.1	6.3	108	7.6	4.8	195	8.5
Total discharges	865	100.0	63.0	1,417	100.0	62.7	2,282	100.0
Total first admissions*	1,374	...	...	2,259	...	...	3,633	...

* Number of first admissions with dementia praecox or manic-depressive psychoses during the year ended March 31, 1946.

included 57.5 and 35.8 per cent, respectively, of the two groups of first admissions. It is evident, therefore, that the outcome for the present-day groups is definitely superior to earlier results, and this must be attributed to improvement with respect to the treatment of dementia praecox, and not to any possible admixture with a manic-depressive group.

We may consider next the rates of mortality among the first admissions with dementia praecox in 1945-1946. Of the 1,218 males, only 43, or 3.5 per cent, died within three years after admission. (See Table 17.) Of this number, over 40 per cent occurred within three months, and 74 per cent within the first year after admission. The death rate averaged 64.8 per 1,000 annual exposures during the first three months. During the first year, the death rate averaged 28.6 per 1,000 exposures. The rate dropped after the first year.

Among the 1,962 female first admissions with dementia praecox, there were 84 deaths during the three-year period, or 4.3 per cent. The death rates were relatively low throughout the period, but the heaviest mortality occurred during the first three months. During this interval, there were 35 deaths, representing 41.7 per cent of the total deaths. The death rate was 75.2 per 1,000 annual exposures. The rate dropped during the remainder of the year, and averaged 30.8 for the year. The rate was very low after the first year.

SUMMARY

This is a third follow-up study of first admissions to the New York civil state hospitals. The patients were admitted during the fiscal year that ended March 31, 1946, and each patient was followed for a period of three years from the date of admission. Included in the study were 5,765 males, and 6,715 females, a total of 12,480.

Of the males, 39.6 per cent were discharged during the period of three years. Of a group of male first admissions from 1910 to 1913, 49.2 per cent were discharged within three years. The corresponding percentages for females were 41.3 and 45.0, respectively. However, the comparisons are probably spurious. It was shown in previous studies that the rate of discharge decreases with advancing age, and is especially low among those aged sixty or over. Of the total first admissions,

sions to the New York civil state hospitals in 1945-1946, 40.7 per cent were aged sixty or over, and 34.1 per cent were aged sixty-five or over. The corresponding percentages in 1913 were only 17.4 and 12.5, respectively. Obviously, therefore, the probability of a discharge was reduced in 1946 merely as a consequence of the age distribution. The study employed as a control did not give the age distribution of the first admissions or their ages at discharge, and it is, therefore, impossible to make the proper adjustments for purposes of comparison.

The changing age distribution is associated with changes in the distribution of the several psychoses. Most noteworthy is the increase in the admissions with psychoses with cerebral arteriosclerosis and senile psychoses. These groups have low discharge rates, which even compare unfavorably with the rates of the earlier generation.

Of special interest is the rate of discharge among general paretics. Uncorrected for the varying factor of age, it appears that 29.1 per cent of the males and 34.3 per cent of the females were discharged within three years, compared with 20.0 and 25.2 per cent, respectively of the earlier group.

First admissions with alcoholic psychoses have rates of discharge that exceed the average, but because these admissions now include large proportions at advanced ages, the average rate of discharge is less than that of four decades ago.

Discharge rates were high in the functional groups (involutional psychoses, manic-depressive psychoses, dementia praecox). The results for dementia praecox are especially interesting. During the earlier period, 51.8 per cent of the male admissions were discharged within three years, compared with 60.6 for the present group. Among females, the corresponding percentages were 35.3 and 58.6, respectively.

Rates of mortality may be summarized as follows: Of the males, 36.0 per cent died within three years after admission. Of the females, 32.8 per cent died within the same period. These are greater than the corresponding death rates of the control group, which were 31.3 and 25.6 per cent, respectively. The excess is undoubtedly due to the increase in the average age of first admissions. The death rates are especially high among first admissions with senile psychoses and psychoses

with cerebral arteriosclerosis. The current death rates among these two groups of patients exceed the comparable rates of the earlier generation. Death rates among general paretics were formerly very high. Because of the new therapies, the death rate has been reduced materially. Among males, the percentage dying within three years after admission fell from 70.5 to 29.1. Among females, they were reduced from 55.7 to 34.3. The newer therapies also resulted in a lowering of the death rate among first admissions with alcoholic psychoses. The death rates were low among the functional groups and lowest among those with dementia praecox. The use of shock therapies did not entail any great risk, as only 3.5 per cent of the males with dementia praecox died within three years after admission, compared with 4.2 per cent during the pre-shock period of forty years ago. Among females, the corresponding percentages were 4.3 and 7.8, respectively.

We come finally to the question of condition at discharge. Of the total admissions, 14.9 per cent were discharged as recovered, and 36.7 per cent were discharged with some degree of improvement, including recovery. These may be compared with corresponding percentages of 20.8 and 37.5, respectively, for a group of first admissions of forty years ago.⁷ As with discharge and mortality, the current rates of improvement are lower than they might have been, because of a less favorable distribution with respect to age. The rates are influenced unfavorably by the evergrowing proportions of seniles and arteriosclerotics.

Of special interest are the rates for first admissions with general paresis and with dementia praecox. Of the former, 4.8 per cent were discharged as recovered, and 28.4 per cent had experienced some degree of improvement. The corresponding percentages forty years ago were only 0.6 and 14.1, respectively. Of those with dementia praecox, 16.4 per cent were discharged as recovered, and 53.5 per cent were improved in some degree. Corresponding percentages for the control group were 5.7 and 29.1, respectively.

BOOK REVIEWS

TO-DAY'S CHILDREN AND YESTERDAY'S HERITAGE: A PHILOSOPHY OF CREATIVE RELIGIOUS DEVELOPMENT. By Sophia L. Fahs. Boston: Beacon Press, 1952. 218 p.

Reading Mrs. Fahs' book is a deep and moving experience for all who are interested in releasing the fullest potentialities of children in their unconscious quest for wholeness, joy, and creativity. Along with this, and unexpectedly, it gives widened vision, deepened insight, and new courage to adult readers. It brings a spiritual quickening through fresh realization that religion in the deeper sense is a vital, living power inherent in every heart and mind, a power that makes us grow and that grows with us. It is heartening to realize anew that we need not remain in the purely negative state of rejecting traditional religion because of its clinging to outworn dogma and its consequent too frequent failure to meet emergent needs in both individual and social living. The reassurance that we, ourselves, may help develop for the children we teach *and for ourselves* a vital, ongoing religion, brings with it a new sense of power and worth.

Dr. Carl Jung is reported to have said, in a recent address, that the most widespread cause of neuroses to-day is the repression of the religious faculty in this predominantly scientific era. To the degree that this is true, Mrs. Fahs' book has great mental-hygiene value for teachers and parents and through them for the children they nurture. Only as we, ourselves, are whole, can we be fully effective in promoting wholeness in others. And the integrating center of true wholeness for all of us is a sense of relatedness and dedication to eternal values—in other words, *religion*.

We have, many of us, been aware of our need in this area, but have lacked the definitive guidance for working in it that Mrs. Fahs provides.

The arresting richness and wisdom one finds on virtually every page of this book have not come about by chance. They are the fruits of years of thought, study, and experience in seeking the deeper meanings of religion and vital ways of helping children find them for themselves through interpreting their own experiences. As instructor of religious education at Union Theological Seminary, and director of the seminary's experimental church school, as well as director for nine years of the curriculum of the church school at New York's famous Riverside Church, Mrs. Fahs has studied the origins and development of all religions, the findings of modern science regarding the nature of the universe and life within it, and the findings of

psychology, psychiatry, and education as they bear upon the development of children, bringing all to a *focus* in so masterful a way that each illuminates the others. The result is a deep and moving new philosophy of religion, presented so simply and with such gripping illustrations from actual experience with children, that one cannot—nor does one want to—escape its full meaning, which is revolutionary in the best sense.

Instead of trying to skim through this book, as one is tempted to do with many books in one's field, one does not want to miss a paragraph in these seemingly short 218 pages. And upon finishing it, one wants to offer the book to every parent and teacher and worker with children, saying, "This is just what we need as a foundation, not only for helping children to a significant religious awareness that grows from within, but to help ourselves to a deeper understanding of and respect for their creative capacities as human beings and ways of releasing them."

The titles of the chapters are, in themselves, suggestive of the freshness and soundness of the approach. They are: *It Matters What We Believe*; *It Matters How We Gain Our Beliefs*; *Natural Beginnings in Early Childhood*; *Natural Beginnings in Children's Curiosities*; *The Old Bible: The Story of Salvation*; *The Bible—Newly Interpreted*; *The Need for Both Bibles—and More*; *Old and New Cosmologies*; *Old and New Moralities*; *An Old and a New World Brotherhood*; *The Art of Group Leadership*; *What Shall Children Study?*; and *How About Worshiping Together?*

In describing the nature of the beginnings of religious experience in early childhood, Mrs. Fahs points out that the child's spiritual development begins at the moment of birth in the emotional matrix in which he grows. The feeling that he is loved and wanted helps him to the feeling of self-worth which underlies his capacity to respond to and love others, a most significant element in religious growth. At three or four, he starts asking the questions that for several years continue with growing interest; "Who am I?" "What am I for?" "Where did I come from?" And these are the questions that underlie religious and philosophical probing from primitive times down to our own.

Emphasizing that a vital religion must be based upon inner personal growth rather than upon outer precept, Mrs. Fahs emphasizes the importance of experimenting with different ways of keeping alive in children the sense of the wonder of life in all its forms which is inherently theirs. She points out that we can pick up anything and if we meditate long enough upon it we touch infinity, illustrating the process by the story of a little girl who picked up a beautiful grain of

sand and kept asking more and more about it. So the child's own experiences can lead to a direct relationship with the universe.

Through the child's curiosity, then, he moves out into the larger world and its history. He has a deep emotional need to feel his relationship to this larger world. He is seeking religion. And he needs to discover that "people have learned all they know about God by seeing for themselves what is in His world."

After a time the child is likely to become curious as to why people do as they do in religious ritual and asks such questions as "Who were the first to pray and why?"

After children have come to understand mankind's need for religion through their own searchings, then understanding may be extended to the significance of religious searching as expressed in the religious myths of many faiths.

Mrs. Fahs believes that when old enough, by the fifth or sixth grade (but not until then for fear of confusion), children need a clear explanation of the Story of Salvation as presented in Biblical scripture, and then the interpretation of these writings by modern scholars. The more orthodox beliefs should be treated with respect and reverence as a record of sincere searching of noble men and the inspiration of many saintly lives. They need to realize, however, that their own religious heritage comes down from all quarters of the earth, so that they may feel spiritually related to people of varying religious backgrounds and realize that "no one can prophecy from which ancestral line some fresh insight may come."

Perhaps the most unique and thought-provoking chapters are *Old and New Cosmologies*, *Old and New Moralities*, and *An Old and a New World Brotherhood*. These, like the book itself, must be read in their entirety to be fully appreciated.

In *Old and New Cosmologies* the author brings to focus the findings of natural science upon the problems of the origins of life and of man, quoting such authorities as Dr. Dobzhansky, who writes that "evolution is a creative response of living matter to the challenges of the environment," and points out that the mystery in this creative response is what we call God. It seems appropriate here to illustrate from her own writing how Mrs. Fahs believes children may be helped by just a little understanding guidance to these profound realizations, how a child's reverent eagerness may be increased by "encouraging his direct awareness of the evidences of creation in the here and now."

- "Nine-year-old John and five-year-old Jill were reaching out in their childlike way toward this basic mystery within the universe. It was spring. For some time gardens and babies had been their chief topics of conversation. Finally, one day, as the two were sitting in the living

room alone while their mother was in the kitchen with the door open between, Jill said to her brother:

"When you plant a bean it just grows and grows into a bean plant and it has little beans and roots and everything. John, how does it know how to grow into a plant?"

"You plant it and the sun shines on it and the rain waters it. That's how it grows," said John, the young scientist.

"But," said Jill, "the sun doesn't know it's supposed to be beans. The seed is under the ground. If we planted a bean and it grew carrots, we'd be surprised. Somebody must know how it is supposed to be. I guess it must be the bean that knows."

"Well, I don't think the bean *knows* anything," said the young scientist with assurance.

"Then Daddy and Mother must know," said Jill puzzled. "I guess that's how it is."

"Daddy and Mother couldn't possibly know anything so wonderful as to how to make a bean plant grow from a seed," said the mother peering through the doorway. "We only know how to plant the seed. We only know that if we plant a bean and the sun shines and the rain falls, then it will grow into a bean plant. That's all anybody knows."

"Jill persisted. "Babies would be harder to make than beans. You and Daddy know how to make babies grow."

"Oh, no!" said the mother. "We only know what to do so that the baby can start to grow. It is like planting the seed. We didn't know anything about you at all until *after* you were born. We didn't even know whether you were a girl or a boy!"

"But you knew I was *me!* Didn't you?"

"No. We're just getting acquainted with you as you grow. We will never know *all* about you."

"Jill was baffled. "Then how did I get to be *me?*" she asked.

"The same way a seed gets to be a plant, I guess," said the mother. "It is wonderful, isn't it?"

"It must be God that knows how" said John, rejoining the discussion. "That's what God is! God is what knows how to grow."

"In this short final sentence, John summed up the new and significant insight that replaces the old idea of creation by God's fiat of a completed and perfect world once and for all in the beginning. Jill sensed that the mystery of the boundless creativity permeating the universe is to be found in even the seed of the bean. After all, the bean seed in some way really does 'know' how to become a bean plant, and in this creative growing life John recognized God as 'what knows how to grow.'

"The great philosopher, Dr. Alfred Whitehead, expressed in mature language what these two children discovered for themselves. 'God is the intangible fact at the base of finite existence.'"

Mrs. Fahs brings out further that modern findings indicate coöperation as a more profound principle in the developmental processes than competition; and "that the whole universe is interrelated, self-regulating, self-governing with the great Power we call God imminent in all," as Dr. L. K. Frank has put it.

This leads directly into the discussion of "Old and New Moralities,"

which presents the concepts of self-regulation and permissiveness as basic principles underlying the development of wholesome ("good") personalities. The author points out that modern findings leave no room for the concept that all human beings are basically sinful. Instead, it is emphasized that children are born actively coöperating organisms with a natural readiness to respond to love and even to struggle for it. Therefore, basic human nature, rightly understood, evoked, and nurtured, favors the "values that all great religions try to promote: love, trust, coöperation." We must, therefore, "trust the child's nature and work with his inborn wisdom instead of thinking it is something to work against." Indeed, the seeds of "salvation" are inherent in human nature, not something that must be brought in by an outside Power.

In this and many other ways it is shown that the barriers put in the way of using psychological insights may be obviated. There is no conflict between science and religion in its deepest sense. Indeed, science is our greatest aid in realizing the ultimate goals of true religion.

In the Chapter, *An Old and a New World Brotherhood*, it is pointed out that "without minimizing in the least the worth of the individual, we need to-day to turn children's attention to the togetherness that is involved in worth-while living. Instead of accenting our independence of others, we need to realize that life never ceases to be a giving and a receiving. If our long-time goal is the salvation of a world community rather than merely the salvation of a few select individuals within this universal community, our concept of individual responsibility is changed and our feeling for our relationship to God is changed. We no longer feel like racers each rushing to gain his own crown of glory" (p. 152).

To this end the author points out that children and youth need to "be led to feel that new discoveries are needed in the realm of religious and ethical living fully as much as in the physical sciences" (p. 153). And, further, "there are always values on both sides of any conflict . . . learning to balance values rather than seeking to oppose one value against another is the new art of living we need to-day" (p. 154).

The chapter on "The Art of Group Leadership" contains a most eloquent summary of the qualities leaders need to release children into creative interaction, outreach, and achievement. It ends: "Leadership means learning to love, especially the child whose attitudes are the most unlovely of all" (p. 158). Here, Mrs. Fahs gives vivid illustrations of how children were helped to feelings of self-worth and warmth for others by such leadership; also, how the rejection by a

group of boys of a planned lesson led a creative teacher to suggest the stimulating and rewarding experience of writing leading scientists regarding their religious beliefs.

The last two chapters, *What Shall Children Study?* and *How About Worshiping Together?* give specific and highly valuable suggestions in these two areas. In the first the author points out that instead of trying to get children to think about "religious things" on Sunday, we should try to help them "think about ordinary things until insights and feelings are found which have a religious quality. . . . The religious way is the deep way, the way with a growing perspective and an expanding view. . . . The religious way is the way that touches universal relationships; that goes high, wide, and deep, that expands the feelings of kinship." And the subjects to be dealt with in this way should include the questions children universally ask about life's three great crises; birth, mating, and death.

The chapter on worship ends with descriptions of meaningful worship services children evolved for themselves out of their own thoughts and longings.

Upon finishing the book, one wishes that all who guide religious growth both in homes and in schools might have this book as an aid. It leaves nothing to be desired except another book by the same author, carrying these concepts still further for the education of teachers and parents themselves.

KATHARINE WHITESIDE-TAYLOR

Baltimore Public Schools

RESIDENTIAL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN; A DESCRIPTIVE STUDY. By Joseph H. Reid and Helen R. Hagan. New York: Child Welfare League of America, 1952. 313 p.

This study of residential-treatment centers for emotionally disturbed children is published as part of a project undertaken by the Child Welfare League of America with the assistance of the Field Foundation. Twelve residential-treatment centers were studied by the authors during 1951 and 1952.

Spencer H. Crookes, executive director of the league, states the purpose of the study in the foreword. He says in part:

"For about fifteen years, those interested in the care and treatment of children have heard reports of a new form of therapy commonly termed 'residential treatment' Though published literature in this field has dealt extensively with many facets of the theoretical base on which residential-treatment centers have been set up, it was apparent that there were few comprehensive descriptions of their actual operation. . . .

"It was the intent of the League to assemble facts through which the clinical experience reported by treatment centers could be better under-

stood. From the beginning it was apparent that any attempt to develop firm 'criteria' or 'standards' was definitely premature. Rather, it was believed that a description of differing methods of practice might serve eventually to furnish a yardstick against which deviations or sharp differences could be measured and evaluated.

"This study, then, is a step toward developing a broader knowledge and understanding of 'residential treatment.' The experience of these pioneering centers should be invaluable as those responsible for their care seek more effective treatment methods for hurt and troubled youngsters."

The following centers were studied: Arthur Brisbane Treatment Center, Allaire, New Jersey; Bellefaire, Cleveland, Ohio; Child Guidance Home of Cincinnati; Children's Service Center of Wyoming Valley, Wilkes-Barre, Pennsylvania; Emma Pendleton Bradley Home, Providence, Rhode Island; Evanston Children's Home, Chicago; Hawthorne-Cedar Knolls School, Hawthorne, New York; Jewish Children's Bureau of Chicago; Langley Porter Clinic, Children's In-patient Service, San Francisco; Neuropsychiatric Institute, Children's Service, Ann Arbor, Michigan; Ryther Child Center, Seattle, Washington; and The Southard School, Topeka, Kansas. Seven of these twelve organizations have medical programs and are administered by physicians; five have social-agency programs, administered by social workers.

The authors state that the number of treatment centers in the United States other than these twelve is not large, and few, it is believed, have developed resources comparable to those described. Briefly, the criteria used in selecting programs to be included were: (1) the program should have as its major function the treatment of emotionally disturbed children in residence; (2) it should be a program providing direct psychotherapy integrated with a therapeutic living milieu; (3) the centers should have control over what children should be admitted; and (4) the programs studied should be representative of the field as a whole.

In the reports of each program studied, an attempt was made to avoid comparative evaluations. The project is intended to be an expository description, not an evaluation. A very general outline has been followed in the description of each center, an outline considering such aspects of the program and structure of the center as form of organization, buildings and grounds, intake policies, children in residence at the time of the study, staff, intake procedures, treatment (with special reference to such aspects of treatment as individual psychotherapy treatment in residence, education program, and work with parents), after-care, training, costs and sources of support, and critique.

The critique is in every instance written by the director of the

center and gives an evaluation of the program and some discussion of the evolution of the particular treatment methods and the philosophy underlying them. It is notable that most of the directors mention insufficient staff and particularly insufficient psychiatric staff as one of the major inadequacies of their programs. Many directors mention the need for more staff for work with parents both during the period while the children are in residence and when they return home.

There is marked variation from center to center in the "diagnosis" of the particular emotional disturbance that brings the child to the center, but the highest percentage of children have been classified as neurotic, schizophrenic, or children with primary behavior disorders.

The appendix includes tables, broken down for each center studied, of annual per-capita costs; salaries of various classifications of personnel; and distribution of ages of children at the time of admission and at the time the study was made. Although there was considerable difference in age range of children among the various centers studied, it is notable that for all of the centers combined, 438, or about 82 per cent of the 531 children in residence at the time the study was made, were between nine and eighteen years of age. Of the 518 who left the centers during the two-year period preceding the study, about 55 per cent had remained in treatment for more than a year. Some children had remained in treatment for more than seven years. Nearly 73 per cent of the children returned to the community, 53.5 per cent to their own homes and the others to foster homes. Twenty-seven per cent went to other institutions.

This brief review should make it obvious that this study of residential treatment is one that professional workers will turn to frequently for guidance with a variety of different problems.

FRANCES P. SIMSARIAN

Washington, D. C.

CHILD ADOPTION IN THE MODERN WORLD. By Margaret Kornitzer. New York: Philosophical Library, 1952. 400 p.

"In 1949 over 17,000 adoption orders were made, yet it is only 25 years since adoption first became legal in this country." Thus, in the first sentence of her introduction, the author at once outlines the magnitude of the problem of child adoption and gives a brief historical background.

Ever since the beginning of human history, there have always been unwanted children—children who, for reasons of illness, death, or social or physical accident, were unacceptable to the main stream of family organizations. Society has always been forced to solve this

problem, to eliminate these individuals, or to incorporate this surplus, yet valued, commodity into the group.

The methods employed have been as varied as they have been chaotic, ranging from infanticide, through slavery, through our modern tendency to consider these youngsters at once a burden and a social fad. Our attitudes toward the surplus child torn out of his traditional family constellation have varied with time and with the cultural and economic pattern into which he was born. This pattern itself, moreover, has often fluctuated, so that a child has sometimes represented a most valued asset, an heir to an estate and wealth, and at other times an economic liability—merely an additional mouth to feed.

Because society has considered the family constellation as the best environment for the growth of children, it has usually attempted in some manner to supply a substitute family when for any reason the original family group has been broken. Hence the legal institution of adoption has developed. Like our attitudes toward these children, however, the social regulations set up to control the adoption process also bespeak their origins and are often not clear as to their central purpose—i.e., as to whether they are set up to defend the biological parent, the adopting parent, society and the institution of property as a whole, or the central (but often non-participating) individual—the adopted child himself.

In this volume, *Child Adoption in the Modern World*, Margaret Kornitzer gives an invaluable, almost encyclopedic, compendium of data on the subject of child adoption, including discussions of the legal, social, individual, and psychological aspects of this great problem.

Her general chapters, *Why Adoption!*, *Concerning Adopters*, *A Child for Adoption*, *The Approach to Adoption*, and *The Mother's Point of View*, are excellent in their presentation of the problem. After discussing the specific legal aspects of the adoption process (many of which are of direct interest only to English workers), she continues with such topics as "Adoption and the Family" and "Telling the Child," both excellently written papers, which could bear reading and rereading by professional workers and parents alike.

An unusual and somewhat controversial section can be found in her chapters, *Adopting the Older Child* and *Difficult and Unadoptable Children*—problems that again emphasize our lack of knowledge and understanding regarding the dynamics of the adoption process and the reasons why people are interested in adopting children.

A large section of Miss Kornitzer's volume is devoted to a necessarily brief and probably sketchy review of adoption procedures in

various countries of the world, including a rather unflattering review of adoption procedures in the United States.

Although the author admits that in the United States adoption is marred by a good deal of old-fashioned and inferior legislation, she also mentions that much work is being done here in the psychological and psychiatric fields of adoption.

The volume is a true compilation of facts and figures of adoption practices in the modern world. As such, it is an invaluable summary and an excellent survey of this field of work. The book points up both the importance of the problem and the progress made in the legal and social areas within the past twenty-five years. The volume's chief lack reflects the big gap still remaining in our knowledge regarding this problem: one is struck by the almost complete absence of research work in this field of applied sociology. The dynamics of childlessness, the psychological basis of the desire for children through adoption, the psychological significance of adoption and adopting for parent and child alike—all of these aspects are still a closed book that must await future study.

This book is broad in its sweep and specific in its suggestions. It is a volume that should be part, not only of the library, but also of the intimate acquaintance, of every serious student of adoption.

ARTHUR L. RAUTMAN

St. Petersburg, Florida

CHILDHOOD EXPERIENCE AND PERSONAL DESTINY. A PSYCHOANALYTIC THEORY OF NEUROSIS. By William V. Silverberg, M.D. New York: Springer Publishing Company, 1952. 289 p.

This is a very difficult book to review for a Journal like MENTAL HYGIENE because each chapter actually consists of two parts. Although it is subtitled *A Psychoanalytic Theory of Neurosis*, one part of each chapter is an attack on the basic concepts of psychoanalysis, particularly on the libido theory and the concept of instincts, which are the cornerstones of all psychoanalytic theory and practice. For these well-confirmed concepts the author would substitute Dr. Harry Stack Sullivan's theoretical formulations.

I would have no objection to his doing so except for his subtitle and the controversial manner in which he engages in what appears to be a duel with Freud. The presentation of Dr. Sullivan's and Dr. Silverberg's views and their differences with the basic psychoanalytic concepts, so that the points of disagreement can be clearly seen, in itself makes a valuable contribution to psychiatric literature. For example, it has always seemed to me that Freud's method of presentation of the case of Little Hans brings out a different point of emphasis between

European and American psychiatry. Little Hans suffered under a number of traumatic experiences before he became ill, and I do not think that Freud tended to minimize or to neglect their effect on the child. At the same time, he insists on the importance of the libido in the causation of the illness. Perhaps because of the influence of the child-guidance movement, American psychiatrists have tended to place a greater importance on the effect of traumatic events in the life of the child as the causation of neurosis. This, I believe, is correct, but not to the exclusion or the de-emphasis of the effects of the libido and libido development as in Dr. Silverberg's book.

The parts of the book that emphasize Dr. Silverberg's disagreement with basic psychoanalytic concepts would be valuable for mature and experienced psychoanalysts to read, so that they could understand Dr. Sullivan's and Dr. Silverberg's point of view, but they would be very confusing to less experienced psychoanalysts, to psychiatrists in general, to social workers, psychologists, and teachers. I would not recommend this book for the latter groups.

The chapters on the psychosexual development of the child—Chapter II. *The Areas of Early Experience*; Chapter III. *The First Experimental Area: Problems of Orality and Deprivation*; Chapter IV. *The Second Experimental Area: Problems of Discipline*; and Chapter V. *The Third Experiential Area: Problems of Rivalry and Genitality*—all provide many interesting examples and discuss many points more fully than is usually done. So they provide a wealth of material to supplement such books as Freud's *Three Contributions to the Theory of Sex* and Sterba's *The Psychoanalytic Theory of the Development of the Libido*.

As I said before, the book portrays one side of a controversy and, therefore, I cannot recommend it for the usual readers of MENTAL HYGIENE. It makes interesting reading for the mature psychoanalyst who desires to understand the point of view of Dr. Sullivan and Dr. Silverberg.

GERALD H. J. PEARSON

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PLEASE EXCUSE JOHNNY. By Florence McGehee. New York: The Macmillan Company, 1952. 241 p.

Among the encouraging aspects of the mental-hygiene movement is the growing realization that, good as individual cure and individual prophylaxis are, sound mental attitudes need all the backing they can get from the social environment. This is one of the reflections aroused by a reading of these well-written chapters.

The writer, for sixteen years a California truant officer, must be a person of exceptional gifts. Indeed her pages would be worth reading

if only because they tell such interesting stories. But her book also brings home in a fresh way the growing need for better interplay between such personal ministration as her own and our schools, our civics, our economic life, every social influence in any way here involved. Between the professed aims of our public schools and the actualities of getting children merely to attend—whether or not they really learn anything—is a wider gap than many of us yet recognize.

The author's work as "hookey cop" lay chiefly in a farm district, where the laborers often were migrant Mexicans, Gypsies, and Americans of the "Okie" type made known to us by *The Grapes of Wrath*. To learn why children stayed out of school and, where necessary, to bring the father up before the law, Mrs. McGehee had to visit the homes. In one of these the mother was a prostitute, parent of a boy of nine who bit off the head of a live bird. In another lived a high-school girl who had murdered an assailant. In other homes were a cretin, an epileptic, an utterly degenerate father.

In one Mexican family, much too large even then for the relatively young mother, when the law was finally called on to send the father to jail for a brief sojourn, the mother was glad to be relieved of his presence; the culprit enjoyed a much too short vacation; and the whole family resented the fact that even after the majesty of the law had been vindicated, the school people nevertheless persisted in demanding that the children go to school.

An Indian family, unable to understand that a child dying of tuberculosis needed to be in a sanatorium, watched her die in their home. An American mother, sure that she knew how business is conducted in her native land, offered the hookey cop a five-dollar bribe to use "influence" to get her discouraged boy moved on to a higher class in school. When the Rotary Club provided money to fit a boy with much needed eye-glasses, a shiftless mother just somehow could not get her son to the oculist's office.

It will be objected that the author, doing a literary job rather than presenting a scientific document, gives only those aspects of the entire problem that lend themselves to her preferred way of treating the matter. Brighter findings in this field could without doubt also be reported. But these we are in less danger of forgetting. It is the unpleasing realities that we would rather not be told.

Mrs. McGehee does not pretend to have all the answers to the many disturbing questions of mental hygiene, adult education, socio-politico-economics, that these cases raise. But her recital tells us how many areas exist that are utterly unvisited by the benefits we assume to be inseparably tied up with modern civilization. Not cars or clothes or the fruits of the earth, but education, is America's biggest industry. Much of its product more than justifies the billions of dollars that it

costs. But the big job will be done better when books like this move more of us to ask, "What can we do to see that the product offered by our schools really enters into the lives of the great numbers who do not get it now?"

HENRY NEUMANN

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MENTAL HYGIENE FOR CLASSROOM TEACHERS. By Harold W. Bernard. New York: McGraw-Hill Book Company, 1952. 472 p.

Nothing is more important in the history of education than the mental-hygiene movement. This movement involves every aspect of education and undertakes to provide at least provisional answers to the most complex educational problems: the nature of man's needs, the effect of need frustration, the nature and cause of conflict, desirable and undesirable response to conflict, and a host of related problems. Mental hygiene has not been able to give final answers to these problems, but for a half century it has focused the attention of educators and research workers on the issues of mental health so vital to the welfare of man.

A great volume of literature on mental hygiene has grown up since Clifford Beer's *A Mind that Found Itself* appeared in 1908. That book, as all know, centered principally upon the problem of improved treatment for the seriously mentally ill. Many years ago I had the opportunity to discuss the mental-hygiene movement with Mr. Beers, and he maintained that even in those early days he had a preventive program in mind, but the literature of the early years showed no clear conception of the relation between education and mental health, particularly education as carried on in the schools.

In the course of time the emphasis in mental hygiene shifted from better treatment for the hospitalized to more hygienic education for children, to the end that serious illness might be prevented at the source. Thus books began to appear about the mental hygiene of childhood, of the school, of education, of the teacher, for it became clear that the schools and teachers were the best hope for a meaningful approach to mental health.

Dr. Harold W. Bernard's *Mental Hygiene for Classroom Teachers* is an addition to this great literature and, in my judgment, makes a contribution to it. A fresh statement of the principles of mental hygiene as they relate to the classroom teacher would be worth while, but Dr. Bernard does more by introducing and discussing some of the newer approaches to mental hygiene, while restating with clarity many of the best known principles developed over the last fifty years.

The author expresses his purpose in these words:

"The purpose of this book is to give teachers a background for understanding the nature of good and poor mental health, to clarify the nature and meaning of the symptoms of inadequate adjustment, and to acquaint the teacher with some of the techniques that can be used for determining the motivations of children who are deviates. A great part of the good that teachers can do in improving the mental health of children lies not in what they can do *for* the child, but in what they do *in front of* the child; that is, the example they set and the classroom atmosphere they create. For this reason, a considerable portion of this book is devoted to a discussion of the factors that condition the mental health of teachers, with a view to providing the teachers with suggestions for (1) removing some of the handicaps and (2) learning to live with those handicaps which cannot be readily removed."

Dr. Bernard undertakes to realize his purpose in the following way: The book is divided into four parts: I. *Basic Considerations*; II. *Mental Hygiene in the Classroom*; III. *Special Approaches to Mental Health*; and IV. *The Teacher's Mental Health*. Part I does a good, solid job on basic problems. Chapter 1, entitled *The Need for the Mental Hygiene Viewpoint*, is one of the best introductory chapters in the literature. The nature of the mental-hygiene problem in modern society, the characteristics of the healthy personality, and the prospects for improvement are skillfully and convincingly discussed. All teachers in preparation and in service would profit from reading this chapter, one of the best in the book.

Chapters 2 through 5 deal with the following problems: human needs in mental health, the nature of maladjustment, meeting the needs of children, and special needs of adolescents.

Part II is probably the most practical section of the book. Here the author reveals a sympathetic and insightful acquaintance with the everyday problems of the classroom teacher and does not hesitate to give some very helpful information and suggestions. Teachers will be interested particularly in a discussion of the effect of teacher personality on pupil behavior, the ever-present problem of discipline, and especially "some questionable school practices." The last chapter in this section, *Constructive Classroom Approaches to Mental Health*, offers a number of positive suggestions.

But it seems to me that Parts III and IV bring a somewhat new and desirable emphasis to the subject. The first three chapters of Part III show how art, writing and drama, and play can be used as special approaches to mental health, especially in dealing with children. These approaches have very promising possibilities. The modern teacher will not want to be ignorant of them. The final chapter in this section is a rare and much needed one in mental-hygiene literature. The title is *Limitations and Precautions Regarding Mental Hygiene*,

and the chapter contains good common-sense warnings against over-enthusiasm and a hope for miracles.

The final part, Part IV—*The Teacher's Mental Health*—opens up what in my judgment is the most important problem in the whole field of mental hygiene, unless, indeed, it is the problem of the mental health of parents. But who would know how to tackle that problem? If the mental hygiene of teachers were good, many other problems would be solved, for the personality of the teacher is the central factor in the educative process. The three chapters of this part which close the book, are good. Writing on this subject may be even better in the future if educators continue to think on the problem and good research is encouraged.

A special feature of the book should be mentioned. In addition to the usual bibliography at the end of each chapter, there is an up-to-date list of audio-visual materials related to the subject matter of the chapter. This material should be very helpful for teacher-training classes and in-service discussion groups.

Teachers of mental-hygiene courses in teacher-training institutions will certainly want to examine this volume for possible use as a text. Organizers of in-service training groups also will wish to see the book. Further, *Mental Hygiene for Classroom Teachers* is recommended to teachers who wish to bring their knowledge of mental hygiene abreast with recent developments. In fact, any serious student of mental hygiene will find interest and profit in this volume.

G. V. PULLIAS

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PLAY, DREAMS, AND IMITATION IN CHILDHOOD. By Jean Piaget, translated by G. Gattegno and F. M. Hodgson. New York: W. W. Norton and Company, 1952. 296 p.

A new book by Jean Piaget is always an intellectual treat. Piaget has the happy faculty of combining a plethora of observation with a minimum of hypothesis, to produce a masterpiece of psychological synthesis. This book is the third of a series. The two previous books, *The Beginnings of Intelligence* and *The Child's Construction of Reality*, dealt with sensory-motor intelligence in the pre-verbal stage—"the phase of preparation for what will later become the operations of reflective thought." The present book, which consists of observations of the same three children, attempts to "bridge the gap between sensory-motor activity prior to representation and the operational forms of thought."

The author's thesis is (1) that there "is a functional continuity between the sensori-motor and the representational, a continuity which determines the construction of the successive structures"; (2) that "the various forms of representation interact." (There is representation when an absent model is imitated, as in symbolic play, in imagination, and even in dreams). Piaget characterizes representation as going "beyond the present, extending the field of adaptation both in space and time." "Representations" involve a double interplay of assimilations (of objects to individual activity) and accommodations (of activity to objects) present and past, tending toward equilibrium. "Until this equilibrium has been achieved, either there is the primacy of accommodation, resulting in representative imitation, or there is the primacy of assimilation, resulting in symbolic play" (p. 273).

The author illustrates these basic concepts by describing the baby's experiences while learning to grasp, shake, swing, rub, and throw an object. He states: "Such behaviors involve two poles: a pole of accommodation, since there must be an adjustment to movements and perceptions to the objects, but also a pole of assimilation of things to the child's own activity, . . . as he finds them useful for a behavior learnt earlier or for one he is in the process of acquiring" (p. 161).

Piaget repeatedly emphasizes that various forms of representative thought—imitation, symbolic play, and cognitive representation—are interrelated and dependent upon the gradual establishment of equilibrium between assimilation and accommodation. He carefully defines these terms (pp. 274-5) and concludes that "on the social plane the child is most egocentric at the age at which he imitates most, egocentrism being the failure to differentiate between the ego and the group or confusion of the individual viewpoint with that of others. . . . In as far as egocentric thought is pre-operational and irreversible, it requires the support of the image and of perception. . . . Rational operations are, in fact, systems of aggregates, characterized by a definite mobile and reversible structure which cannot be explained by neurology, sociology, or even psychology save as forms of equilibrium towards which the whole development tends" (p. 291).

The author's style, as reflected in the excellent translation by Gattegno and Hodgson, is that of the philosopher, the epistemologist, and the methodical, astute student of science who never writes for a popular audience. Piaget is well known to his English-speaking colleagues for his previous investigations of the child's "language and thought," "conceptions of the world," "moral judgment," "judgment and reasoning," and "physical causality." His chief interest always has been the genetic aspects of the nature of thought organi-

zation and the stages of development that the thought process must pass through to attain maturity.

The present book is divided into ten chapters. The first three comprise Part I, *Imitation*, which is divided into six stages: (1) preparation through the reflex; (2) sporadic imitation; (3) systematic imitation of sounds; (4) imitation of movements already made by the child, but not visible to him, and the beginning of imitation of new auditory and visual models; (5) systematic imitation of new models; and (6) beginnings of representative imitation and further development of imitation—(a) deferred imitation, (b) further evolution, (c) theories of imitation.

Part II consists of chapters IV. to VII., and is devoted to the exposition of play—the beginnings of play, classification of games and their evolution after the beginnings of language, explanation of play, and secondary symbolism in play, dreams, and "unconscious" symbolism.

Part III, entitled, *Cognitive Representation*, includes chapters VIII. to X.—transition from sensory-motor schemes to conceptual schemes, from practical to representative categories, and conclusions, general trends of representative activity. An excellent index is provided.

The author briefly summarizes his results as follows:

First period: sensori-motor activity.

Second period: egocentric representative activity (instead of objective adaptation, there is assimilation of reality to the child's activity).

Third period: stage I: preconceptual thought; stage II: intuitive thought.

Fourth period: operational representative activity. Adapted thought reaches a state of permanent equilibrium (at about age seven or eight) on the plane of concrete operations, and at about eleven or twelve, on that of formal operations. During this period imitation becomes reflective (subordinated to the ends pursued by intelligence). Play follows an exactly similar line of development.

This book is not easy reading; the author frequently refers to controversial, continental, academic matters of terminology, philosophy, and psychology. He briefly discusses the contributions of Groos, Guillaume, Buytendijk, Claparéde, Wallon, Buhler, Lange, and many others.

Piaget is of the opinion that, "in spite of appearances, Freud is much less of a geneticist than he is usually considered to be, and he too often sacrifices development to permanence, to the extent of ascribing to the baby at the breast the attributes characteristic of the final stage of development—memory, consciousness of ego, and so on. What is needed, therefore, is a genetic transposition of the Freudian doctrine

through elimination of those elements which make it too much a science of the permanent." Piaget proceeds to do just that. His astute criticism of the Freudian explanation of symbolic thought and his evaluation of the contributions of Silberer, Adler, and Jung (Chapter VII) are well worth the price of the book to every serious student of psychology and psychiatry.

JACOB H. CONN

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ON THE BRINGING UP OF CHILDREN. Edited by John Rickman. Second Edition. New York: Robert Brunner, 1952. 243 p.

This is the second edition of a book familiar to child psychiatrists and others since its original publication in England in 1936. The small volume includes six essays originally presented as a public lecture course in 1935: *Planning for Stability*, by Ella Freeman Sharpe; *Weaning*, by Melanie Klein; *The Uses of Sensuality*, by Merell P. Middlemore; *Questions and Answers*, by Nina Searl; *Habit*, by Susan Isaacs; and *The Nursery as a Community*, also by Susan Isaacs.

The preface to the original edition, by John Rickman, is included, as well as a brief preface to the second edition and a postscript by Melanie Klein. John Rickman, the editor, died during the preparation of the present volume and three of the co-authors, Susan Isaacs, Merell Middlemore, and Ella Sharpe, died in the interim between the publication of the two editions. Melanie Klein has added seventeen more recent references to the original list of twenty-five.

The essays are all oriented educationally rather than therapeutically. This is not a book on how to deal with the problem child or even the normal problems of childhood. It is rather a contribution to preventive psychiatry. It aims to show how the atmosphere of the home and the attitudes, conscious and unconscious, of the parents, both the father and the mother, influence and modify the development of the child's personality. This is not a book that places the blame for all the neurotic ills of childhood on the parents. It presents in clear, non-technical language a picture of the child's own intricate mental and emotional activities. One might describe it as a series of essays on the child's pre-genital development. Each chapter points out potential areas in which environmental factors can be conducive to wholesome individual development or destructive to such development. This book is for the educator, the professional worker, or for the intelligent, well-educated parent. It is not a handbook for unsophisticated parents, like Benjamin Spock's *Baby and Child Care*, or Sidonie Gruenberg's *Your Child and You*.

The educational philosophy that runs through the book is clearly grounded in the contributions of Sigmund Freud and the British school of child analysis. The paramount importance of unconscious needs and motivations is repeatedly stressed. The child's concept or phantasy of himself, of his parents, and of the world around him will unconsciously determine his future attitudes and reaction patterns. These concepts and fantasies are strongly colored by the emotional climate of the home and the parents' attitudes toward their parents, toward themselves and each other, and toward their children.

A child's aggressive impulses and pre-genital sexual drives can be variously met by those on whom the child is emotionally dependent. The unconscious attitudes more than the conscious acts of those on whom the child is dependent for gratification will determine the child's attitude toward his own aggressive and sexual impulses. Anxiety, feelings of guilt, inadequacy, and insecurity can inhibit or distort the development of the child's full potentialities. Specific and particularly repeated traumatic events have far-reaching results, not in terms of the event itself, but in terms of the infant's phantasy constructions. These will depend in part on the level of the child's psychosexual development and the relationship he has with love objects. The magical thinking of infancy and the patterns by way of which the child deals with fear, guilt, or frustration are significant determinants of personality.

Susan Isaacs, whose two essays constitute nearly half of the book, summarizes the philosophy of the authors in her final paragraph:

"These detailed studies might all be summed up by saying that what seems to us psycho-analysts to be desirable is that the nursery should be a place where fathers and mothers, nurses and children alike, are real persons and allow each other to be real persons, with real pleasures and real activities; where there is sincere emotional response, and feelings are not covered over or forced into rigid patterns by rules or formulae. It is desirable that adults shall be themselves and allow children to be children. If they appreciate the real feelings and real personalities of their children, they will not be afraid to demand that the children, too, shall recognize their personal reality and rights. Neither respect for abstract law or personal dignity, nor the unconscious sensual satisfaction of the parents, should be sought at the expense of the living growth of real children. Parents should keep their eyes on the child's future and have faith in his growth and development, whilst allowing him to live as fully and freely as he can on his own present level of love and achievement."

This book will be a valuable addition to the libraries of American analysts, child psychiatrists, child-guidance workers, pediatricians, and educators of young children, and a limited number of parents.

Americans are in general more familiar with the contributions of Anna Freud and will welcome this capsule presentation of the Melanie

Klein point of view. Her essay in particular seems, in its theoretical aspects, rather speculative and will, I believe, stimulate reading of her books, in which she has more opportunity to substantiate her statements.

FLORENCE CLOTHIER

*New England Home for Little Wanderers,
Boston, Massachusetts*

ON BEING INTELLIGENT. By Ashley Montagu. New York: Henry Schuman, 1951. 236 p.

Though Professor Montagu (of Rutgers University) is a learned anthropologist, he remembers that the plain people to whom this book is addressed expect a language that is simple. Such readers—and others, too—are often tempted by modern psychology to think the power of intelligence a mere trifle compared with the influence of their passions. They will be reassured by the author that the comparative powerlessness of intellect is all the more reason for using the gift to the full. How else can life receive order and be directed sanely?

For this reason Dr. Montagu emphasizes the fact that, important as it is to be an individual, the healthiest self-fulfilment requires right relations with other individuals. "Human happiness, like the whole of human culture, is a social product," which can be bettered by intelligence.

In each chapter this thesis is applied to a problem like "psychosclerosis," or to the illusion of the angry man that he is strongest when he erupts in rage. One illustration must suffice. In the chapter, *Unintelligence in Sex*, Dr. Montagu warns parents against harming their children by treating masturbation as morally evil. He wants sex education to begin early, before playmates introduce their own misleading views. He deflates the ego of the person who boasts, whether aloud or in silence, of sex conquests. He makes much of the distinction between selfish sex gratification and love. The latter needs self-giving, tenderness, unfailing heed to the fact that the finest human relations are coöperative and that a need which is essentially coöperative will never be satisfied by a conduct essentially self-indulgent.

He does not write about people already so troubled as to require the services of the psychiatric expert. But ordinary persons will find in these chapters many shrewd suggestions for putting a sound good sense into their human relationships.

HENRY NEUMANN

Brooklyn Society for Ethical Culture

CYBERNETICS. Edited by Heinz von Foerster, Margaret Mead, and Hans Lukas Teuber. New York: The Josiah Macy, Jr. Foundation, 1952. 240 p.

This book presents the transactions of the Eighth Conference on Cybernetics, held in 1951 under the sponsorship of The Josiah Macy, Jr. Foundation. The conference consisted of conversation groups on six subjects in the field of communication: (1) Communication Patterns in Problem-Solving Groups; (2) Communication Between Men: Meaning of Language; (3) Communication Between Sane and Insane: Hypnosis; (4) Communication Between Animals; (5) Presentation of a Maze-Solving Machine; and (6) In Search of Basic Symbols. The discussion leaders were, respectively, Alex Bavelais, Ivor A. Richards, Laurence S. Kubie, Herbert G. Birch, Claude A. Shannon, and Donald M. McKay.

Museums, zoos, and art galleries are fascinating to their connoisseurs, even when the subjects are specialized. Here we have an opportunity to look into another kind of display, which for convenience might be called a communications exhibition. Six halls are open at this time; there are doorways, however, through which many more are visible.

Human beings are on display in the first hall, five of them, gathered around a table which is partitioned off so that they cannot talk to one another, but may communicate in writing through tubes arranged in patterns of a fan, a chain, or a line. The people do not know the pattern. "Each person holds in his hand cards with symbols. The problem is to find the symbol common to the group either in the shortest time or using the shortest number of messages.

Director Bavelais moves here and there with eagle eye, stage-managing the affair, taking notes, and persistently asking such questions as: "Did your group have a leader?" "Did you find its pattern of communication?" "Who was the leader?" "How well did you like the job you were doing?" "What kind of things prevented your group from doing better?"

Director Richards greets us at the entrance to the second hall with a conundrum: "To come back to my doubts, a penetrating doubt, truly a bosom doubt, concerns the sort of language with which one may profitably try to talk about language." Mr. Kluver responds, "There would be nothing but confusion if we used everyday language to talk about the very brain which created this language."

In one corner of the hall a group of Yana are talking, carefully choosing their words to show whether the speaker or some one else vouched for the words he spoke. A Hopi conveys the generality of his statement through the verb and not the noun. There is a bear

"taping for a special run of the manipulative-perceptual mechanism" in his search for ants on a boulder. Yonder are pupils learning to read by acquiring the use of only a few letters at a time, each of the reversed letters—p, b, q, and d—being introduced as single strangers to a group of familiars. Here and there, among bears, Indians, and children, Richards darts asking, "How do you describe communication?" "How do you tape-forward the hierarchy of memory symbols that guide behavior?"

In the third hall Director Kubie is surrounded by humans in a variety of states of consciousness—sleep, deep concentration, hypnosis, and psychosis. There is the young man who saw Kubie at a dance on Saturday, but reported Monday in a psychiatric interview that he had had a dream that he saw Kubie at the dance. There was a woman who reported dreams of strange green daffodils such as she had never seen—which she suddenly discovered were the designs on the bronze lamp in the office, which she saw consciously for the first time.

Comfortably seated on a fireplace, one psychotic is easily interpreting the symbolism used by another. Kubie hovers around and asks, "Are there special systems of communication available to the mentally ill, not normally available to the rest of us?"

In the fourth hall Director Birch hovers over hives of bees and cages of chimpanzees. There is even a pool of scallops which flee as rapidly from a spoonful of starfish broth as from the star fish himself. As for the bees, the finder of nectar is going into a figure-8 dance, with wiggles at the crossing to tell his companions how far away the flower is and in which direction. "The wiggles per second are correlated to the distance away by a constant very near to the speed of sound," says Birch. "Perhaps for the bee sound is the universal constant that the velocity of light is in man's electromagnetic philosophy."

The chimps do not seem to care. An older female is making love to a younger male. Suddenly the same symbol that was first used to request her submission becomes the request for her to beat the "living daylights" out of him.

In his cubicle Director Shannon is demonstrating his machine, whose finger can memorize the pattern of a 25-square maze and resolve it to the goal, and which can "profit" by experience to avoid error. But just wait until the goal is removed entirely, and watch the finger go into a puzzled, confused, neurotic dance. The machine is an animated, overgrown network of electromagnets which reduces to machinelike proportions certain characteristics of the human mind.

In the sixth hall Director McKay displays a tremendously imposing array of cosines, vectors, probabilities, with here and there a

logarithm as well. Hovering overhead is entropy, that law of thermodynamics concerning the decrease of free energy in the natural world.

In this literally figurative atmosphere are a group of players of "Twenty Questions." "Information theory," says McKay, "defines the amount of information as the minimum number of such questions logically necessary to determine the selection." There, wrapped up in a few words, is the unit of measure that has lain beyond the grasp of man for a couple of generations when he needed it badly. With a proper measure, information can be dealt with by science and the significance of the probabilities, the vectors, and the anthropy becomes evident.

One has to go to this communications exhibition to appreciate what it is doing. Where one question is answered, perhaps ten new ones are asked. Such is the manner of this younger of the sciences which draws into it students from all the other sciences. They await the answer to the question: With what language shall we talk about language?

I hope the leaders of these six discussion conferences will forgive my presenting their sessions as I have. As I read through the book, these sessions appeared to me as mirrors repeating a vast range of laboratory and clinical work which, in the short space available to this review, might be more easily comprehended in that fashion.

LEWIS BALDWIN

Missouri Division of Employment Security, St. Louis

WHO ARE THE GUILTY? By David Abrahamsen, M.D. New York: Rinehart and Company, 1952. 340 p.

Crime is a barometer of the social climate, and the causes that bring about atmospheric variations are not more numerous than those that bring about the phenomena of social maladjustment. The eternal question of nature versus nurture is always under discussion, and with the growth of science the emphasis shifts from one to the other. One gets the impression that because the emphasis has been misused, we often are overly cautious about ascribing causes when they indicate a certain fatalistic destiny.

One thing about Dr. Abrahamsen's contribution is notable—his optimism. With all due allowance for the lack of success up to date in handling crime, his hope is in the future contribution of economics, sociology, and psychology. This always raises the question of skilled technicians in these fields who might be able, through knowledge and its application, to ameliorate some of the trends toward which our universal social structure is now tending.

It is not alone because communication has been so broadened that we are aware of the malignancy of the problem of crime or some of

its veneered aspects, as exemplified in totalitarianism. Dr. Abrahamsen, like many others, prefers to look at this problem as a pandemic infection that has spread through the world. While he specifically refers to the crime situation in this country, his propositions are just as valid for other cultures so far as concerns their specific concepts as to what constitutes acceptable or social conduct. His classifications are simple and, like all classifications, are subject to change with growing knowledge. His recommendations are essentially educational, which raises the eternal problem as to how far education can actually function through mass orientation. Surely, if we consider the growing percentage of literacy in this country and the ever-expanding number of college-trained people, we must ask ourselves why we still have as much crime as we ever did.

The problem is conditioned by the fact that sound learning is rather an emotional than an intellectual experience, that living and doing rather than theory bring about results. The educator is by no means a teacher alone. How will he guide the teachers who in turn guide the parents? While it is true that adult education is an imperative need for resolving some of the factors that bring about asocial conduct, Dr. Abrahamsen is correct in ascribing crime to many elements—inheritance, defective somatic endowment, environment (which he emphasizes a great deal), and the philosophy of success, which is often conceived of in terms of power based on materialism and pragmatism rather than upon the true Christian aspects of growth.

Crime is, then, an index of the current status of the Christian spirit, the ultimate in man's growth. Science and art are handmaidens for that purpose, but always in a subservient capacity, for man's growth is the amalgam of his knowledge and of his relationships toward others. The criminal loves himself pathologically; the Christian loves others honestly. In simple terms, Dr. Abrahamsen evolves this theme and brings to bear our current knowledge and experience with the sick to help accomplish more successful end results. He dissects our present system and its shortcomings.

Who Are the Guilty? is simply written; it is fair and modest in its presentation; and it is heartening in its courageous effort to bring about change for the better.

EDWARD LISS

New York City

HISTORY OF AMERICAN PSYCHOLOGY. By A. A. Roback. New York: Library Publishers, 1952. 426 p.

This volume is the first attempt to present a history of American psychology from the beginning of the pre-scientific period down to

the present. The first section is concerned with psychology from its colonial beginnings to the transition period in the 1880's. This is followed by a section on the pioneers in the development of scientific psychology. Then comes an exposition of the rise of schools and their leaders. The final chapter deals with the growth of the various branches of psychology.

The discussion of pre-scientific psychology (c. 1640-1880) is based largely upon an analysis of the texts used. Psychological instruction in colleges was pretty much in the hands of churchmen. However, independent textbooks began to appear about 1800. Some of these—as those by B. Rush and T. C. Upham—gave a respectable parentage to American psychology. Dr. Roback apparently missed one of the more important authors of this period—J. Buchanan, whose *The Philosophy of Human Nature*, appeared in 1812. Furthermore, he has failed to differentiate satisfactorily between these early nineteenth-century contributions and the less satisfactory later writings (1845-1885) which presented a predominantly a weak version of Scottish psychology in the interest of piety and morality.

The second section, which deals with the establishment of scientific psychology and with the pioneer contributors to the movement, is the best part of the book. The tempo of the movement, the evaluation of personalities, and the exposition of the trends are dealt with in an interesting way and fairly adequately.

In considering schools and types of psychology, the discussion is uneven in quality. It would seem that the author views the contributions of W. McDougall through rose-tinted glasses, and that he is considerably less than objective in discussing J. B. Watson and behaviorism. The six-page digression employed to establish the rôle of Jews in the Gestalt movement might well have been omitted.

The final chapter, on the expansion of American psychology, is little more than lists of names, selected apparently without much discrimination, to represent important contributors to various branches of psychology.

In general, the author does a commendable job in discussing the pre-scientific period, the establishment of scientific psychology, and the contributions of American psychologists to certain systematic movements. The development of trends and research programs at various universities from about 1910 on are dealt with in less satisfactory fashion.

Certain other criticisms occur to the reviewer. The author's practice of employing to an excessive degree Latin, French, and German words and phrases, as well as esoteric words, such as logomachy, coryphaeus, and feuilletonist, tends to become annoying to the reader.

Again, there are several minor errors in the text. Sanford (pp. 134 and 154) was in charge of the Clark research laboratory from the beginning (1889) rather than the college laboratory. There was no Clark College (undergraduate) until 1900. On page 187, H. P. Weld is listed as a student of Titchener, but he obtained his Ph.D. at Clark University. Kurt Lewin (p. 266) was professor of child psychology, not director of the Child Welfare Research Station, at Iowa University.

The serious student of psychology history will question some of the author's interpretations (*i.e.*, that W. McDougall is the foremost psychologist in all English-speaking countries). However, the author has produced a readable treatise that will be welcomed by all those interested in the origin and development of psychology in America.

MILES A. TINKER

University of Minnesota

ALCOHOL EDUCATION. A GUIDE-BOOK FOR TEACHERS. By Joseph Hirsh. New York: Henry Schuman, 1952. 90 p.

This is a timely book, crystallizing, in a condensed form, our present-day knowledge about alcoholism. Written by a man who has been actively engaged in research on the problem, it is filled with valuable information.

That misery stalks in the wake of uncontrollable drinking is well known to every one, yet the immensity of the problem, as it relates to national welfare, is not at all clearly perceived by the average citizen. In an introductory chapter, the author presents the issue clearly:

"Alcoholics clutter municipal courts and jails, multiply public welfare costs enormously, contribute immeasurably to conditions that bring about broken and disturbed homes, and numerous other problems in society as pervasive as they are persistent. People who drink excessively, whether they do so voluntarily or because they are sick and cannot help themselves, have added dramatically to the nation's already frightening tolls of traffic and other accidents. It is with that in mind that every state and the District of Columbia require by law some instruction about alcohol in their public schools."

The author points out that drinking in moderation has become an integral part of fashionable living. It has been fostered and encouraged by the industry in intensive advertising campaigns which emphasize all of the glamour and none of the menace associated with the consumption of alcohol. Some state legislators have recognized the gravity of the problem, as indicated in the following state statute:

"The radio, the moving picture, and the press are being used by profit-seeking individuals and corporations to enhance the sedative and narcotic

destructive habits of life. . . It becomes necessary, not only to instruct pupils regarding the harmful effects of all forms of narcotics upon the human body, but also to deflate the supposed value of such stimulants."

The author feels that too much emphasis has been placed on fear in the present-day teachings of the harmful effects of alcohol, and that many inaccuracies are being disseminated regarding the effects of alcohol. The purpose of his guide, he declares, is to disseminate in a condensed form authoritative and up-to-date information on the subject, and to lead those who are interested to further investigation in the various source books available.

After a discussion of the problem from an historical perspective, he devotes a chapter to evaluating the chemical properties and physiological effects of alcohol. In another chapter he takes up the "disease" called alcoholism. He points out the fact that alcohol does not bring about alcoholism. Emotionally maladjusted and immature persons make up a large percentage of alcoholics. These, as well as the high-strung, tense, and neurotic individual, stand in danger of becoming alcoholics, once they discover that alcohol offers them a temporary state of tranquility—a sense of oblivion from worry and unhappiness.

He discusses the various aspects of the problem in a series of question-and-answer paragraphs, formulated by him and his students. He evaluates the various forms of therapy available to the alcoholic. He formulates a program of teaching the subject, and presents a bibliography on alcoholism, including a series of films available on the subject.

This is an invaluable source book on alcoholism. Its chief merits are brevity and reliability. It is chuckfull of information on a subject with which every public-spirited citizen, especially ministers, teachers, doctors, and social workers, should become thoroughly familiar.

SAMUEL PASTER

Memphis, Tennessee

LIVES IN PROGRESS: A STUDY OF THE NATURAL GROWTH OF PERSONALITY. By Robert W. White. New York: The Dryden Press, 1952. 376 p.

Neither the merits nor the limitations of this book are overwhelming. In reading it, one is disappointed and one is rewarded. In reviewing it, one is puzzled to know what judgments to make.

The author states in his preface that his purpose has been "to provide a brief introduction to the whole field of personality." Three extensive case histories of "normal" college students, two men and one woman, occupy the bulk of the pages. These are accompanied by interpretations and interpretative summaries. There are also special

chapters elaborating the social, biological, and psychodynamic orientations in the understanding of lives. Emphasis is placed on the integration of all three approaches. The book is concluded with its most productive chapter, one on the process of natural growth:

It seems unlikely to this reviewer that *Lives in Progress* can serve as an adequate introduction to the field of personality. The writing is too complex and the discriminations too subtle. The more advanced student, on the other hand, should find the book an excellent review and synthesis which will enable him to see his technical knowledge in the perspective of lives as a whole.

Perhaps the most important contribution of the book is to make available broad accounts of the lives of college students who were not psychiatric patients. The data were derived entirely from autobiographies, interviews, test materials, and college records. In all three cases, information was obtained while the subjects were in college (Harvard and Radcliffe) and again some years later. The presence of follow-up material of this sort is in itself cause for rejoicing. Further, the inclusion of a woman subject lends distinction.

But it seems that the claim of the title that this book presents lives in progress and is a study in the natural growth of personality is somewhat exaggerated. What it does seem to present is the retrospective impressions of three individuals of their own developmental experiences, plus psychological measurements made at entirely arbitrary points in that development. The title suggests what one would like to see: systematic longitudinal studies that would include both direct observations and interviews with persons who contribute to the social context within which the individual is developing, as well as the retrospective personal impressions and test data given here. Probably this sort of thing is more nearly approached by the University of California Growth Study.

The author reports that a very large number of professional assistants contributed to the collection and understanding of these data. He has brought unity into the interpretations by making all of them himself. This reviewer wonders if one step in the interpretation that would have added greatly to the depth of the final integration of the data has not been overlooked. Would it not have been well if separate specialists in the biological, social, and dynamic interpretations of lives could have made the first abstractions from the data, to be followed by a synthesis prepared by the author? It seems that a spurious unity may have been introduced by the use of a single interpreter.

Readers of this journal will have special interest in the author's section on the concept of mental health. He takes up the cause of a positive, developmental criterion as opposed to a negative or con-

formity criterion. There is no question of the advantages of such a standard and of the need to promulgate it. One does question his conclusion that the task of rearing and guiding children can best be represented by the metaphor of raising plants. It is a helpful figure of speech, but would seem to glorify the biological roots of personality at the expense of the social and dynamic contributions to individual lives. Dr. White will not take it amiss if we suggest that the case of Joseph Kidd, here in its third incarnation, has been worked hard enough.

This should prove a useful and interesting book for students and for laymen with some background in the technical interpretation of human development.

DOROTHY CLIFTON CONRAD

*University of Alabama Extension Center,
Montgomery, Alabama*

PSYCHOTHERAPY WITH SCHIZOPHRENICS. Edited by Eugene B. Brody and Frederick C. Redlich. New York: International Universities Press, 1952. 246 p.

This monograph presents a symposium held at the Yale University School of Medicine in 1950. The participants are eminent authorities in various aspects of treating schizophrenics, and they do much toward clarifying and summarizing current thought in the field.

A comprehensive introduction by Dr. Robert P. Knight sets the framework for the stimulating discussion. After this, Dr. Redlich reviews the literature on the various concepts of schizophrenia, and Dr. Brody summarizes current thought on the treatment of schizophrenics. Five original papers are then presented, each discussed thoughtfully and effectively.

The high light of the book, in the reviewer's opinion, is Frieda Fromm-Reichmann's paper, in which she discusses clearly and concisely the principles and methodology that she utilizes in her effective work with schizophrenics. She compares her work in a specific, definitive way with that of John Rosen and Federn. Dr. Fromm-Reichmann's paper is discussed by Drs. Jacob Arlow and David Wright, who expand on some of her points from their own experience.

Kurt Eissler then differentiates between frank schizophrenic states and the "mute" states, outlining the therapeutic approach that he recommends with each. He emphasizes the importance of the therapist's feelings in his work with the patient and goes so far as to say that the therapist must have strong "rescue fantasies" if he is to succeed in therapy.

Drs. Ruth and Theodore Lidz present an important concept in discussing the area of disorder in border-line and latent schizophrenics. They emphasize the close symbiotic relationship that exists with the

mother and feel that the essential area of disorder in these patients is the lack of definite ego boundaries with regard to the mother. The entire therapeutic régime is based upon this dynamic formulation.

Dr. Milton Wexler presents an interesting, if not generally accepted, hypothesis—that therapy can best proceed if the therapist acts as an auxiliary superego in order to strengthen the superego of the patient. Dr. Robert Bak and Dr. Ludwig Eidelberg question Wexler's hypothesis on the basis of their experience.

Experiments in group therapy are effectively presented by Dr. Jerome Frank from his work in this field. Dr. Frank stresses the value of constructive utilization of interpersonal group relations and defines and contrasts the various attitudes and rôles of the group leader. Dr. Elvin Semrad enlarges upon Dr. Frank's paper from his experience at the Boston State Hospital.

Dr. Lawrence Kubie closes the symposium by stressing the need for better defined working hypotheses, so that more specific and valid experimental conclusions can be reached. He recognizes that the complexity of the problem of schizophrenia makes a planned experimental approach difficult, yet such an approach is essential if research is to be productive.

Reading the monograph is a rewarding and stimulating experience for those interested in the treatment of schizophrenics. The editors and the authors present basic contributions in the field that clearly constitute a large part of the armamentarium of the student of schizophrenia. The symposium should be helpful to all trained workers in the field of schizophrenia—physicians, social workers, and psychologists alike. Not the least important part of the book is the useful bibliography that appears at the end of each section.

EDWARD M. DANIELS

*Veterans Administration
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THE NATURE OF NONDIRECTIVE GROUP PSYCHOTHERAPY—AN EXPERIMENTAL INVESTIGATION. By Leon Gorlow, Erasmus L. Hoch, and Earl F. Telschow. New York: Bureau of Publications, Teachers College, Columbia University, 1952. 143 pp.

After several readings, and four futile attempts to write an intelligible review of this book, this reviewer has drawn the conclusion that an ordinary "review-context" does not exist. The book is a composite of three doctoral dissertations. It deals with a stringently circumscribed "experiment" in a field that has long since grown beyond the scope of the three authors' knowledge.

The "experiment" involved seventeen university students, divided into three groups, in a series of nineteen sessions. The number of group sessions was determined by the length of the academic semester.

The students volunteered for this "experiment." They were chosen on the basis of being "deeply concerned about some area of personal difficulty." The difficulties are not individualized, but are listed as including: "difficulty in concentration, extreme tension when talking before formal groups, doubt about vocational plans, difficulties in parental relationships, and generalized feelings of inadequacy."

There is no explanation for the use of the word, "psychotherapy," in the title and text of this book. None of the participants was diagnosed as ill. One of the students diagnosed herself as "neurotic in the sense that she felt herself 'over-reacting' to the ordinary stresses and strains of everyday life." The authors claim no cures or rehabilitations. The original "difficulties" are not declared "alleviated." What relevance the "experiment" has to treatment is left to the reader's imagination.

Immediately after the selection of the participants, the focus of the authors shifts to changes in behavior within the groups. What happened to the individuals in the group is generally referred to as "most profited" and "least profited," in graph and table form. What was "profited" is not indicated. Two "paper and pencil" tests were administered at the conclusion of the "experiment." Who did what with these tests is not indicated. The authors seem more interested in the behaviors of "groups" in this specialized setting. They do not tell the reader what value the participants derived as a result of the experience.

There is one almost amusing contrast between the attitude of the authors toward their own work and that toward another experimenter's in "nondirective psychotherapy." On page 20, they scold H. Peres for not having administered the Rorschach as an objective test of results. Peres had a series of six sessions, involving seven students. In regard to their own results they say (p. 35), "Since the Rorschach may be describing a basic personality structure which might be intractable to short-term psychotherapy and since the literature reports conflicting results in its use as an instrument to measure therapeutic gain, it was abandoned in favor of the other two [paper and pencil] tests."

A further complicating element in this composite dissertation is the compelling desire displayed by the authors to dispense with the psychoanalytic theory of personality. "What the present study attempts to demonstrate," they say, "among other things, is that several of the more significant process dynamics can be adequately understood in terms of specified, measurable variables without the necessity of invoking debatable symbolic concepts."

Since the authors present no evidence to the effect that they are trying to achieve the goals of psychoanalytic therapy, it is quite

possible that they can understand their "process dynamics" without "symbolic concepts." Their polemics about "transference" and "insight" (pp. 9-11 and 58-60) add nothing but confusion to their presentation of an idea that bears but slight resemblance to treatment of mental and emotional illness.

These are some of the peculiarities of this book that prompted the conclusion that it might better be viewed and reviewed as something different from an ordinary book on psychotherapy.

CHARLES G. MCCORMICK

New York City.

COLLEGE AND LIFE: PROBLEMS OF SELF-DISCOVERY AND SELF-DIRECTION.

By M. E. Bennett. Fourth Edition. New York: McGraw-Hill, 1952. 457 p.

Those who have first-hand acquaintance with the needs of the average teen-age campus novitiate, will welcome this rather complete and now—in its fourth edition—more readable compilation of orienting information and aids to study and learning. Freshmen college students have always had to go through the struggle of emancipation from home, to acquire rather suddenly more adequate study habits and techniques, and to complete their adolescent striving toward long-time goals and character values. The desirable stability and philosophy of life are not of course immediately forthcoming, but a start must be made.

The general insecurity of this age, the residuals of the war-time speed-up in condensed curricula, the emphasis on specialty training, and the general crowding in colleges have intensified the confusion among students as well as faculty.

Mr. Bennett's efforts have produced a text that will serve as an aid to a systematic approach to these situations. The three parts—*Life in College*, *Learning in College*, and *Building a Life*—are self-explanatory, dealing as they do with adjustment values, goals, efficient study, and critical learning techniques. Personality development and balance are specially emphasized in one half of the book.

In past years students in most colleges have had more leisure and time to mature, with closer attention from advisers, a situation not usually possible with to-day's crowding. Now there is a definite need for orienting courses, such as are outlined in this text, to help the student integrate and gain discernment. Indeed, the faculty, as well as the youth, in most colleges should benefit from reading this book.

Of special value would be the clues given as to the importance of campus activities. Selective readings and the stimulus to form goals are specially emphasized and well outlined. The chapters on clues as to the nature of learning, on effective studying and remembering, and on the importance of developing the ability to absorb information

by rapid reading are well outlined and should be of inestimable value in helping the student avoid many pitfalls. The same could be said of the treatises on note-taking, the values in reviewing and in progressive organization of a field of study. Thinking with purpose and critical thinking are outlined simply and helpfully, with a warning against defensive rationalization. Many students who develop in rather haphazard fashion would benefit greatly from having the above information called to their attention.

Part III, *Building a Life*, gives in eleven short chapters a brief, over-all, simplified course in human psychology, with much emphasis on self-analysis, will power, and self-direction. In Chapter 20 there are very meaningful, quite excellent descriptions of the stages of growth and of psychosexual development. The next chapter, on frustrations and the treatment of hostilities, is perhaps necessarily fragmentary from the orthopsychiatric point of view. The remainder of the section treats of the achievement of mental health, a philosophy of life, and planning for marriage and home, in a condensed, simplified form suitable for the average immature, but healthy youth or his sister. The discussion of achieving a democratic citizenship is brief, but clear, excellent in fundamentals, and, the reviewer would feel, very practical.

The text could be criticized on the basis that it might arouse anxieties in neurotic students, especially with the use of the self-evaluation exercises that are added to most chapters. It might be said that this is another effort to spoon-feed the average college student. It readily could be argued that there is not enough room in a crowded curriculum for such an orienting course. It could be said also that adequately prepared students would not need much of the contents of the book. The last part, on building a life, could be criticized for a superficial treatment of a very involved subject. Yet one cannot but congratulate the author on having organized so much pertinent information on the present-day needs of college students. There is an extensive bibliography and appendix, which could serve as a guide to further investigation should a student or faculty member be especially interested.

The text in no way attempts to meet counseling needs, which presumably would be available in some form on the average first-class college campus. But it may be that the availability and use of such a presentation as this book would lessen the strain on advisers and counselors.

To conclude, this is an excellent guide for the average, non-neurotic, normally developing adolescent or post-adolescent college youth.

GEORGE M. LOTT

Pennsylvania State College.

NOTES AND COMMENTS

WORLD FEDERATION FOR MENTAL HEALTH ESTABLISHES A COMMITTEE OF HONOR

The World Federation for Mental Health has established a Committee of Honor for the federation. Individuals, in many countries and from the various professions, who have pioneered in work for mental hygiene and in the mental-health field are being invited to become members of this committee. The federation honors itself by having this group of pioneers associated with it.

The following people from the United States are among those invited to membership: Mrs. Clifford W. Beers, Dr. Haven Emerson, Mr. Homer Folks, Dr. William Healy, Dr. C. W. Hincks, Dr. Ellen Potter, and Prof. C. E-A. Winslow.

A TRAINING COURSE FOR REPRESENTATIVES OF STATE AND LOCAL MENTAL-HEALTH ASSOCIATIONS

Executives, staff members, and representatives of state and local mental-health associations came to New York August 17 for four weeks of special, intensive instruction on the task of organizing for the nation-wide fight against mental illness.

The training course, sponsored by The National Association for Mental Health and the National Institute of Mental Health, was held at the Carnegie Endowment Information Center.

Among the instructors were Dr. Robert H. Felix, Director of the National Institute of Mental Health, of the U. S. Department of Health, Education, and Welfare; Wilbur I. Newstetter, Dean of the School of Social Work, University of Pittsburgh; Dr. Paul V. Lemkau, professor of public-health administration, Johns Hopkins University; Dr. Luther E. Woodward, of the New York State Department of Mental Hygiene; and Edith Stern, author of several books and pamphlets on mental illness.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION HOLDS SEVENTH ANNUAL CONFERENCE

The Association for Physical and Mental Rehabilitation held its Seventh Annual Scientific and Clinical Conference at the Mayflower Hotel, Washington, D. C., July 20-24, taking as its general theme: "Rehabilitation—Integrating Science and Service." Papers, panel discussions, and demonstrations made up the program. Sectional

meetings were also arranged for medical and rehabilitation personnel in all the various specialties.

Among the subjects discussed at the panel sessions were "Rationale for Activity Therapy," "Rehabilitation of Patients with Spinal Cord Injuries," "Techniques for Normal Self-Care Activities," "The Social Rehabilitation of the Patient," "Theoretical and Observed Varieties of Motivation Toward Recovery," "Functional Ambulation for Patients with Orthopedic Handicaps," "An Intensive Program of Corrective Therapy for the Psychiatric Unit of the General Hospital," "Activity Therapy for the Regressed Psychiatric Patient," "Rehabilitation of the Cerebral Palsied Child," "Bridging the Gap Between the Hospital and the Community," "Developmental Aspects of Curricula and Training in Correction Therapy," and "The Rôle of the Hospital in the Preparation of the Patient for Living with Disabilities."

The address at the banquet meeting was given by Honorable Walter H. Judd, Representative of the Fifth Congressional District of Minnesota, who spoke on "The Human Story of Rehabilitation."

Among the papers were one on the theme of the convention—"Rehabilitation—Integrating Science and Service"—by J. T. Boone, Vice Admiral (MC) Navy, Rtd., Chief Medical Director, Veterans Administration, Washington, D. C.; and one by John Eisele Davis, Chief of Corrective Therapy, Veterans Administration, Washington, on "Historical Development and Evaluation of Corrective Therapy." Other papers were *Suggestions to the Corrective Therapist Involved in Scientific Inquiry, Research, and Reporting*, by J. Q. Holsopple, Assistant Chief, Clinical Psychology Section, Psychiatry and Neurology Division, Veterans Administration, Washington; *Research, a Distinct Responsibility of the Corrective Therapist in the General Medical and Surgical Hospital*, by Paul Fleer, Chief of Corrective Therapy, V.A. Hospital, Dublin, Georgia; *U. S. Army Reconditioning Program in Japan*, by Willis P. Denny, Captain, M.S.C., Chief of Physical Reconditioning, U. S. Army Hospital, Fort Jackson, South Carolina; and *The American Legion and Veterans Rehabilitation*, by T. O. Kraabel of the National Rehabilitation Commission of the American Legion.

A SYMPOSIUM ON GERIATRICS

Methods of treatment and problems in the care of geriatrics were discussed at a two-day geriatrics symposium sponsored by the Veterans Administration and the Peninsula Academy of Medicine (Virginia) September 24 and 25.

The sessions, which were held at Old Point Comfort, (adjoining the Veterans Administration Center, Kecoughtan) were attended by

leaders in the field of geriatrics and allied specialties. Among those who had prominent places on the program were: Dr. Edward J. Stieglitz, of Washington, D. C., editor of *Geriatrics*; Dr. Lloyd Thompson, professor of psychiatry, Bowman Gray Medical School, Winston-Salem, N. C.; Dr. George M. Piersol, University Hospital, University of Pennsylvania; Dr. Walter O. Klingman, associate professor of neuropsychiatry, University of Virginia; and Dr. Reno R. Porter, associate professor of medicine, Medical College of Virginia.

Among the subjects discussed were the follow-up aspects of geriatric treatment, including social case-work and nutrition; the contributions of physical medicine and vocational rehabilitation; cardio-vascular conditions in the aged; and certain surgical aspects.

In arranging the program, the Veterans Administration Department of Medicine and Surgery coöperated with the staff of Kecoughtan Center, which includes, besides an acute hospital of 470 beds, a domiciliary home with nearly 1,400 veterans, their average age falling between sixty and sixty-five.

The sessions were attended by some 300 people from the area from New York to Georgia and from Virginia to Kentucky.

SOCIAL SCIENCES RECEIVED LARGEST SHARE OF ROCKEFELLER APPROPRIATIONS IN 1952

A total sum of \$16,640,355 was appropriated by the Rockefeller Foundation in 1952, according to its recently issued annual report. Of this sum, the largest appropriation—\$4,366,835—went to projects in the field of the social sciences.

The aim of the foundation's program in this field, as expressed by Dean Rusk, president of the foundation, in his foreword to the report, is "to aid the growth of men and of knowledge in the social sciences and the application of such knowledge to human problems and needs."

"A wide diversity seems to characterize the studies of interpersonal and intergroup relations for which grants were made during 1952," President Rusk stated. "All are addressed to one issue: the problems of human behavior and relations involved in living and working together in a progressively more complex and integrated society. We no longer have the privilege of moving away from our problems and frustrations and taking up new land; most of us have to live in closely knit communities and work within integrated organizations."

"Thus, the study of the effect of differing patterns of supervision on employee productivity and morale in a large insurance company carried out at the Survey Research Center of the University of Michigan; or the study of social relations in a steel mill in Germany by the Dortmund Center for Social Science Research; or the study of intergroup hostility and harmony by Professor Muzafer Sherif at the University of Oklahoma; or Miss Margaret Mead's study of the effects of modern social

change on the natives of one of the Admiralty Islands, are all parts of one whole: the study of the effort of human beings to live and work together with some degree of success and understanding.

"To avoid the holocaust of war and to find the way to honorable peace are among man's deepest yearnings. The responsibility belongs to all. Public officials have the burden for action, but they need all the light they can get and the backing of an informed citizenry. By supporting the work of thoughtful and objective scholars in the field of international relations, the Foundation is enabled to assist in the effort to bring a greater understanding of the issues confronting this country and the world.

"Thus, the grants to the Brookings Institution, the Council on Foreign Relations, and the Royal Institute of International Affairs aid scholars in the analysis of the great issues that confront us. Such scholars do not make the great decisions; that is the task of government and men of affairs. The efforts supported by the Foundation may be regarded as part of the service of intellectual supply to those who carry responsibility for action or teaching or interpretation in international affairs. In that sense, such grants serve to strengthen the strands that bind peace together.

"Our economy, our human relations, our international relations, our social morality, and the growth of new scholars and scientists are fields to which Foundation grants in the social sciences during 1952 have been applied."

AVERAGE DAILY CENSUS OF PATIENTS IN PSYCHIATRIC HOSPITALS HIGHEST RECORDED

The following statement appears in the 32nd Annual Report of the Council on Medical Education of the American Medical Association: "Although there are only 585 psychiatric hospitals, they have a greater bed capacity—732,999—than is found in any other group. Again the average daily census of patients in the psychiatric hospitals is the highest that has been recorded in this field. The present total of 704,056 compares with 697,521 in 1951; it represents 53.7 per cent of the daily patient load in all registered hospitals."

VOCATIONAL COUNSELING FOR SERIOUSLY DISABLED VETERANS

The Veterans Administration now is providing vocational counseling to seriously disabled veteran patients in Veterans Administration hospitals, to aid them in getting well and to restore them to productive life.

Admiral Joel T. Boone, U.S.N. M.C. (Rtd), Chief Medical Director of the Veterans Administration, explained that vocational counseling is designed to aid tuberulous, neuropsychiatric, and long-term general-medical and surgical patients. It is this type of long-term patient, he said, whose employment is interrupted by an extended hospital

stay or who cannot return to the same type of job because of physical reasons, who especially needs vocational counseling.

Here is a typical case history of how vocational counseling helped a tuberculous veteran patient on the road to physical and economic recovery.

Johnny Jones was medically discharged from the army in 1945 with a service-connected tubercular disability and began working as a plasterer's helper. Six months later, his disease became active again and he went into a Veterans Administration hospital for three years. After he left the hospital in 1948, he returned to his old job.

In 1951, he was back in the hospital, with nothing to look forward to but another long siege in bed and worries about his wife and two children.

When Johnny's physical condition began to improve, his ward physician decided that it was time to look toward the future. Johnny could not return to plastering because of his physical limitations and the possibility of further reactivation of his tuberculosis. As a key member of the rehabilitation service, the vocational counselor was called in for consultations. The counselor and Johnny had several discussions on Johnny's feelings toward his disability, his ambitions, and his interests.

Johnny liked mechanical work. He was given a battery of scientific tests to determine what he could do best after his discharge from hospital within his physical limitations.

He finally selected radio and television repairing and was soon learning the rudiments in the hospital's manual-arts-therapy shop. His outlook on life immediately improved. In the meantime, the counselor sought the help of social-service workers, state-employment offices, and veterans' organizations in Johnny's community.

By the time he was ready to go home, Johnny had a part-time job with a neighborhood radio and television repair shop. This enabled him to get the rest he needed so as to build up tolerances against the disease. Now his employer plans to put Johnny on full time as soon as his physical condition permits.

Admiral Boone said that the abilities and interests of long-term patients must be carefully explored and professionally evaluated if they are to be properly placed in productive activities that will allow them to become self-respecting, independent, useful citizens in their home communities.

Although this new vocational-counseling program has been in effect a little over a year, Johnny Jones's story already is being repeated time and again, showing that the program is developing successfully.

Currently, vocational counseling is an integral part of the hospital team in 54 hospitals. The Veterans Administration goal is to extend this service to 32 more, which will cover all tuberculosis and neuro-psychiatric hospitals and those general-medical and surgical hospitals that have large numbers of long-term patients.

PRENATAL PROGRAM AT DUKE UNIVERSITY SEEKS TO DISPEL EXPECTANT PARENTS' FEARS

Duke University is seeking to raise the standard of child-bearing in the South by bringing the care of expectant mothers out of the realm of the "hush, hush." Through a new prenatal program for public patients, first of its kind in the Southeast, Duke Hospital obstetricians hope to reduce the incidence of the three major causes of death in child-bearing by relieving the fears and anxiety of expectant parents.

In a series of movies, lectures, and demonstrations, the Duke obstetric staff is teaching both mothers and fathers the facts of child-bearing and debunking the old wives' tales that make them fearful.

"Many expectant mothers are extremely frightened, although there is little reason to fear such a natural process," says Dr. R. N. Creadick, associate professor of obstetrics and gynecology and supervisor of the program. "Fear and misunderstanding," he explains, "form the psychological bases for many of the complications of child-bearing."

Once every other week, Dr. John Ashe, director of the program, conducts classes for expectant parents at Duke Hospital, explaining the story of reproduction and normal birth. While classes are limited at present, Duke doctors hope to expand facilities further to eliminate misinformation and further to reduce the incidence of the major causes of death in child-bearing: hemorrhage, toxemia, and infection—in that order.

All of these causes are largely preventable, the doctors say.

Infection, now last in the order, used to be the leading cause, but antibiotics have greatly reduced this. Toxemia (high blood pressure and convulsions) is largely the result of inadequate prenatal care, the obstetricians state. Most deaths from toxemia and hemorrhage result from the patient's waiting until too late to see a doctor or to go to the hospital.

The problem of hemorrhage has not yet been solved, mostly because doctors in some towns do not have ready access to blood banks.

One reason why some patients wait too long to see a doctor is that they are afraid, and because they don't understand the need for prenatal care, the doctors say. Duke's prenatal program will promote

more personalized care for the mother when she understands the need, and will give doctors the chance to save lives that otherwise might be lost.

For these reasons, Duke obstetricians are encouraging the patient to express her feelings. "The pregnant woman must be allowed and encouraged to express all her doubts and anxieties," they explain. "If she doesn't mention any of the common old wives' tales, we deliberately enumerate them, since some women are afraid to mention them. Certainly she will hear many more during her pregnancy."

Some of the tales are as absurd as these: "Don't paint; you will poison your child." "Don't hang curtains; the cord will hang the child." "Witnessing horrible events, or even having evil thoughts, will maim your child."

The doctor has to know what the patient thinks—what false ideas have been built up about pregnancy and childbirth—if he is going to eliminate fear, the doctors say.

For instance, many people say that an expectant mother is in a "delicate" condition and should not exercise. On the contrary, most women can and should carry on normal activities, including the sports that they usually enjoy, so long as the exercise is not too strenuous.

Some people think you can starve the child by not eating enough or make him fat by eating too much. The fact is the child's weight is almost totally independent of the mother's gain or loss.

In dispelling false ideas about child-bearing, Dr. Ashe and the Duke staff explain the whole process to parents, including how the egg is fertilized, how the baby develops, and how it is delivered. They also point out the ordinary complications and common complaints of pregnancy.

In conjunction with the prenatal program, the Physical Therapy Division of Duke Hospital conducts special exercise classes for the mothers. The exercises are optional, and a small fee is charged. Many of the exercises were formulated in a widely-known method of "natural childbirth." Some are used to help relax certain muscles as an aid to labor, and others are to develop muscles for pelvic support and comfort during the later months of pregnancy.

In addition to the lectures, movies, demonstrations, and exercises, the program includes a tour of the labor and delivery rooms by the mothers so that they will know what to expect when their child is born.

Duke doctors stress diet and exercise, but do not attempt to persuade the patient to accept a particular method of childbirth (for example, "natural childbirth" or strong sedatives) unless emergency demands use of a particular method.

"To eliminate the major causes of death, parents have to be relieved of needless fear of child-bearing," the Duke obstetricians conclude. "Duke is a teaching hospital and we think it is our responsibility to create a better standard of child-bearing for parents."

ACADEMIC PROGRAM IN STATE SCHOOLS TO BE DIRECTED BY NEWLY APPOINTED SUPERVISOR OF EDUCATION

Charles I. McAllister, of West Hempstead, L. I., has been appointed supervisor of education, a new position in the New York State Department of Mental Hygiene, according to a recent announcement by the department. The appointment became effective October 1.

The new supervisor will direct the further development of the academic program conducted for children in state schools for mental defectives. Establishment of the position was recommended to Governor Dewey during the legislative session early this year, after a study of the state-schools-education system made by the state education department.

For the past seventeen years, Mr. McAllister has been connected with the New York City Board of Education bureau for children with retarded mental development. He taught classes for the mentally retarded in the city elementary and junior high schools from 1936 to 1946, and since that time has been supervisor of this program.

Mr. McAllister is a graduate of New York University, with B.S. and M.A. degrees. Since 1947 he has taught at summer sessions of Teachers College, Columbia University, and at various times given special courses at Brooklyn and City Colleges and at the University of Miami in Florida.

WESTERN RESERVE INTRODUCES SOCIAL SCIENCES INTO SOCIAL-WORK CURRICULUM

As part of a unique program at its School of Applied Social Sciences, Western Reserve University, Cleveland, Ohio, to-day named a Detroit, Michigan, social scientist to the faculty to introduce social sciences into the professional social-work curriculum.

Visiting professor of social sciences for a three-year period will be Dr. Joseph W. Eaton, who will be on leave from the faculty of the department of sociology and anthropology at Detroit's Wayne University.

According to Dean Margaret Johnson, of Western Reserve's School of Applied Social Sciences, Dr. Eaton will introduce into the social-work curriculum current material and points of view from the

related social sciences, such as cultural anthropology, social psychology, political science, economics, and so on.

Work done at Western Reserve under Dr. Eaton's supervision will be financed by a \$50,700 gift from the Russell Sage Foundation, to be granted over a three-year period. The visiting professor will be a teacher and consultant both in the master's program and on the doctoral level.

TWO LECTURES ON MENTAL HEALTH AT NEW YORK ACADEMY OF MEDICINE

Two lectures on mental health will be presented under the A. Walter Suiter Lectureship at the New York Academy of Medicine, on Thursday evening, November 5, at 8:30 o'clock. The speakers will be: Dr. John C. Whitehorn, Henry Phipps Professor of Psychiatry, The Johns Hopkins School of Medicine, Baltimore, whose subject will be "The Acquiring and Imparting of Mental Health," and Dr. Frederick C. Redlich, professor and Chairman of the Department of Psychiatry, Yale University School of Medicine, who will speak on "The Influence of Environment on Mental Health."

This is the seventh in the Suiter series, which is made possible by a bequest to the academy from Dr. A. Walter Suiter, of Herkimer, New York, who had a special interest in public health and in medical jurisprudence. Dr. Suiter was active in the establishment of the state board of medical examiners and was a member of the board for a number of years. He died in 1925.

Previous lectures in the series have been delivered by Dr. Stuart Mudd, Philadelphia; Dr. John R. Paul, New Haven; Mr. George St. J. Perrott, Washington, D. C.; Dr. Harry Most, New York; Dr. Yale Kneeland, New York; and Dr. David T. Smith, Durham, N. C.

PUBLIC HEALTH SERVICE'S CLINICAL CENTER OPENS AT BETHESDA, MARYLAND

The new 14-story clinical center of the National Institutes of Health, Public Health Service, at Bethesda, Maryland, was opened for patients in July. The center will operate as a combined clinical and basic research facility, bringing together scientists representing practically all the clinical and laboratory specialties. Patients will be admitted solely on the basis of a diagnosis that meets the requirements of a particular study. Special coöperative relationships will be developed with hospitals and health agencies for the care and observation of patients after discharge.

THE V. A. MENTAL-HYGIENE CLINIC MEETS A PATIENT

(Reprinted by permission from the Information Bulletin of the Psychiatry and Neurology Division, Department of Medicine and Surgery, Veterans Administration, Washington, D. C.)

The following composite picture of a mental-hygiene-clinic patient is the work of Mrs. Jeanne Caughlin, psychiatric social worker at the V. A. Mental Hygiene Clinic, San Francisco, California, who translated statistics from an analysis of data by Richard Sears, Ph.D., and Harold Geidt, Ph.D., clinical psychologists, and Lawrence Robinson and Helen Blum, psychiatric social workers, all of them on the V. A. mental-hygiene-clinic staff, San Francisco, California.

"What kind of a person is a psychiatric clinic patient? What does he look like, would you spot him if you saw him on the street? Is he different somehow? Or is he an ordinary American who goes to the doctor with his particular ailment, even as you and I?

"In case you have ever asked these or similar questions, you are not alone. The staff of the V. A. mental-hygiene clinic at 49 Fourth Street has been asking them, too, and coming up with some answers from their cumulative experience. A long, close look at clinic statistics over the past three years has provided them with raw material for creation of another kind of average person—an average psychiatric-clinic patient. Using their findings, let's draw a picture of him as he comes to life out of the jumble of tables and figures—as he would appear to you if you were a clinic staff member, meeting him for the first time.

"In the first place, he would most likely be a 'he.' This is because the V. A. mental-hygiene clinic exists to treat veterans for service-connected psychiatric illness, and most veterans are male. This does not mean that the clinic discriminates against female veterans; there have been and are some women patients. However, they are a minority group.

"In the second place, he might be a member of any of the racial groups represented in our cosmopolitan community. The clinic patient population is divided among these groups in the same proportion as they are represented in the total population; no one racial group is more or less likely to make use of psychiatric care. Chances are, this new patient would be a young man: 40 per cent of all patients are thirty or younger, while 78 per cent have gone no further than a fortieth birthday.

"In appearance, our man would be dressed for work, as two-thirds of the clinic patients are employed when they enter treatment. The remaining one-third have a good statistical chance of becoming employed during our association with them. About one-half of those

men who were unemployed at the beginning of treatment, and who remained in treatment for at least ten interviews, become employed during that time. Furthermore, he is likely to have a good work record. Half the clinic patients have worked consistently and changed jobs only by way of accepting positions. Neurological patients, including men suffering from epilepsy, have proven themselves particularly reliable employees.

"So our new acquaintance will be in his usual outfit. This may well be the 'good, conservative suit' of the business or professional man, as a high proportion of clinic patients are in professional or semi-professional occupations. The clinic percentage is 18 per cent, as compared with 11 per cent in the Bay Area. There are students in treatment, and there are men of various skilled trades. The percentage of patients occupied in unskilled labor is somewhat less than in the population as a whole.

"Now let's go a step beyond the first quick look at our patient, and discover a few things about his life. To begin at the beginning, he has quite possibly come from a 'broken' home—a home without one or both parents or adequate substitutes for them. Forty-one per cent of the clinic patients have lost at least one parent, almost always in the crucial first sixteen years. Clinic findings in this regard are strikingly similar to discoveries made in the field of juvenile delinquency. Again it is learned that loss of parents imposes severe problems on children—problems which become manifest in various troubling symptoms.

"In spite of this initial handicap, the clinic patient is likely to have a good education. One-third have had academic or vocational training beyond the high-school level; 27 per cent have attended college, compared with 21 per cent college alumni in the population of the San Francisco-Oakland area. This is not taken to imply that the psychiatric treatment is reserved for people with high foreheads, or that educated people are more nervous than others. Army statistics show that more highly educated people were, if anything, less likely than others to acquire an illness leading to a neuropsychiatric discharge. Clinic figures seem to mean simply that people with more education are more likely to seek psychiatric treatment. Perhaps they have just had a better chance to hear about it.

"After school, or perhaps in the middle of it, our hypothetical patient went into the armed forces. He may have been a seaman or a sergeant or a major, but whatever his service or his rank, he probably stayed quite a while. Almost two-thirds of the clinic patients served at least two years, and an equal number spent some portion of this time overseas. All acquired their 'psychiatric illness in service. However, they are not as a rule receiving high rates of

disability compensation. Our 1952 figures show that 28 per cent receive no pension; their only compensation is the provision of V. A. psychiatric care. Only 13 per cent receive more than 70 per cent compensation; 60 per cent of the group draw 30 per cent or less.

"The new patient has a 50/50 chance of being a family man; half of the patients are married. A little over one-fourth have been divorced at some time. This figure corresponds to the national average, as one-fourth of all American marriages end in divorce.

"So far we have said nothing about the illness which brings our new acquaintance to the clinic. Perhaps it has been severe in the past, perhaps he has been hospitalized once or many times. Probably he does not feel too well as we meet him.

"Psychiatric sickness may take many forms, all uncomfortable. Ninety-five per cent of the clinic patients come because of physical symptoms caused by emotional tension; most of them are referred by doctors. These symptoms may be ulcers, asthma, or muscular pains, as well as headaches, nausea, or insomnia. There may be some difficulty in seeing the world as it actually is, there may be intense worry for no clear reason, or the patient may find himself painfully upset by trivial things. Whatever our patient's symptoms, they are real and distressing. As we meet him, he is taking the sensible—but not so easy—course of seeking the appropriate professional help."

ANNOUNCEMENTS OF MEETINGS

News of latest developments aimed at preventing disease and promoting personal and public health will be exchanged by professional workers from all parts of the free world at the Eighty-first Annual Meeting of the American Public Health Association and annual sessions of 40 related organizations at the Hotels Statler and New Yorker, New York City, November 9-13.

More than 5,000 public-health workers—physicians, dentists, nurses, engineers, statisticians, veterinarians, sanitarians, nutritionists, health educators, entomologists, biologists, and others—are expected to attend the sessions, according to the association's executive secretary, Dr. Reginald M. Atwater. The theme of the meetings will be "Meeting the Health Needs of the Community."

"The association's annual meetings serve to bring to the attention of professional workers in the field of public health the latest findings and views of their fellow workers and thus to stimulate further research and development," Dr. Atwater said in announcing the plans.

"Year after year, milestone after milestone in public-health progress has been recorded at these meetings as man has won battle after battle in the ceaseless war against disease. At the 1952 annual meeting

in Cleveland, for instance, conclusive findings were first released on the use of gamma globulin to prevent poliomyelitis. Again this year, we look forward to hearing news that will bring new hope for longer, healthier, happier life to people everywhere."

Among areas in which progress reports are scheduled, according to Dr. Atwater, are further developments in the use of gamma globulin for polio prevention, mass vaccination against influenza, fluoridation of food and water supplies, new methods of tuberculosis treatment and care, and integration of mental health in public-health departments.

Sessions will be devoted to industrial hygiene and sanitation, school health programs, nutrition and dietary developments, control of animal disease, maternal and child health, accident prevention, home nursing, laboratory and engineering developments, and work with handicapped children of various types.

High lights of the sessions will be the presentation of the Sedgwick Memorial Medal for distinguished service in public health, scheduled for Wednesday evening, November 11, and presentation of the Lasker Awards for 1953 for outstanding contributions in medical research and public-health administration, scheduled for Thursday afternoon, November 12.

The American Psychosomatic Society will hold its Eleventh Annual Meeting at the Jung Hotel in New Orleans on Saturday and Sunday, March 27 and 28, 1954.

The program committee would like to receive titles and abstracts of papers for consideration for the program by December 1, 1953. The time allotted for the reading of each paper will be fifteen to twenty-five minutes. The committee is interested in investigations in the theory and practice of psychosomatic medicine as applied to adults and children in all the medical specialties, and in contributions in psychophysiology and ecology.

The program committee requests that abstracts be submitted in quadruplicate to Dr. George L. Engel, 551 Madison Avenue, New York 22, New York.

The Eighty-first Annual Meeting of the National Conference of Social Work will be held in Atlantic City, May 9-14, 1954. Although arrangements have not yet been completed for conference headquarters, the following hotels will be available for associate group headquarters: Traymore, Ritz Carlton, Brighton, Ambassador, Chelsea, Madison, President, Shelburne, Mayflower, and Senator.

The registration service and the exhibits will be in the Auditorium.

Hotel reservation forms will be mailed to members of the National Conference of Social Work early in the fall and will be available to

non-members on request at the national office, 22 West Gay Street, Columbus 15, Ohio. All those planning to attend the 1954 annual meeting are urged to make their hotel reservations as early as possible.

Despite every effort of program committees to secure as annual-meeting speakers, not only the acknowledged leaders in the field, but qualified people who may not yet have achieved national recognition, it is inevitable that many with genuine contributions to make have been overlooked.

In an effort to remedy this situation and to extend participation in annual-meeting programs as widely as possible, the executive committee has approved a plan of "talent scouting," to be put into effect immediately. The procedure to be adopted experimentally is this:

Any individual in the field of health and welfare who believes that he or his organization has a contribution to make is asked to submit to the national office an abstract of not more than 300 words summarizing a proposed paper. This abstract should be accompanied by (1) an assurance that a full text of the paper will be available in advance if requested; (2) an assurance that a final text of the paper will be ready in April, 1954, if it is to be on the program; and (3) a statement as to whether or not the author could, if invited, be in Atlantic City to deliver the paper in person.

All abstracts received will be forwarded to the appropriate section or committee for consideration along with other program suggestions. It is proposed that any such papers accepted for inclusion on the program be scattered through the regular sessions, indistinguishable from those that have been written at the explicit request of the section or committee.

Although it will not be possible to consider abstracts received after October 1, for the 1954 program, they will be held for the 1955 program committee if the content makes this feasible.

It goes without saying that there is a great deal of fine experimental work going on in local and state communities throughout the country. Because the purpose of the annual meeting is to provide a democratic forum in which all diverse points of view may be heard, and in which all advances in professional knowledge and techniques may be shared, the National Conference of Social Work urges that individuals and organizations accept this opportunity to make their experience available to the field as a whole.

An International Congress for Psychotherapy will be held at Zurich from July 21-24, 1954, under the auspices of the Swiss Medical Association of Psychotherapists. The subject for discussion at the Congress will be: "Transference in Psychotherapy."

"This subject," according to the preliminary notice of the congress,

"leads on naturally from that discussed at the last congress held at Leiden in 1951, which met to consider affective relations in general. Transference is a special form of those relations which is of the utmost importance to the psychotherapist.

"Further, transference is historically one of the most important conceptions in the development of psychotherapy in our time; it was Freud who first made psychotherapists aware of this factor which plays a predominant part in all treatment.

"The question now arises whether the nature of transference was fully demonstrated by Freud's definitions, or whether fresh aspects of it have come to light in the course of the last fifty years. What importance is attached to transference by the various schools of psychotherapy? Has a deeper insight into its nature had any influence on its use in the psychotherapeutic process?

"The aim of our congress is a clarification of these and other questions which most deeply concern the future of modern psychotherapy."

It is proposed to have five or six papers read at general meetings, and a larger number in the subsections, "all dealing with the nature and importance of transference in general psychotherapeutic practice and clinical psychiatric treatment, in child psychotherapy, in general medicine, and psychosomatic disorders. The subsections will also deal with the ethnological, historical, and sociological aspects of transference."

Attendance at the congress is open to all psychotherapists who (a) are members of a national association of psychiatrists or of a recognized society of psychotherapists; or (b) are qualified doctors or qualified lay practitioners who are not members of such an association, but are recommended in writing by its president or two of its members. For further information write to The Secretariat International Congress for Psychotherapy, Zurich, 1954, Theaterstrasse 12, Zurich 1, Switzerland.

The International Institute for Child Psychiatry will meet for two days—August 13 and 14, 1954—at Toronto, Canada, immediately before the Fifth International Congress on Mental Health. The theme of the institute will be, "Emotional Problems of Children Under Six." Each member association of the International Association for Child Psychiatry has been asked to invite and to select clinical case studies and research material from within its own country.

The executive committee has decided on the following plan of organization for the institute: On the first day, Friday, there will be morning and afternoon section meetings. These will be working groups, each composed of not more than 60 people. Each section will spend the entire day in the discussion of one prepared clinical

case. Members will remain with the section for which they register. On the morning of the second day, Saturday, there will be larger group meetings to consider research material that is pertinent to the cases discussed on the previous day. There will be a plenary session on Saturday afternoon with the presentation of papers based on the broad principles that emerge from the case studies and research material.

Early in 1954 an international preparatory commission will meet to select the case studies and the research reports to be presented at the institute. This commission will also attempt to distill, from the material submitted, the principles that will form the basis for the papers to be given at the plenary session. It will not be possible to present all of the material in detail at the institute, but a full list of the contributors will be published.

Many psychiatrists and child-guidance clinics have been invited to contribute material and a guide for the preparation of the case studies has been sent to them. There presentation must be suitable for a group of people with a variety of professional and cultural backgrounds.

For further information, write Miss Helen Speyer, Executive Officer, International Association for Child Psychiatry, 1790 Broadway, New York 19, N. Y.

RECENT PUBLICATIONS

A 16-page booklet, with the intriguing title, *Haunted House*, and a cover that fully lives up to the title, has recently been brought out by the New York State Department of Mental Hygiene as a part of its public-education program. "Are You Living in a Haunted House?" is the theme of the booklet, which deals with fears—fears of the "ghosts" of the past, the present, and the future. It is profusely illustrated with amusing cartoons interpersed with pithy bits of text.

"Fear is a normal thing," the booklet states reassuringly. "Every one has worries and anxieties and they serve a real purpose. But when fear gets out of hand, it's unhealthy—it makes us tense, irritable, and unhappy—it interferes with our lives.

"The way to keep your worries from getting too big for you is to look them in the eye. Drag them out, talk them over, do something about them if you can—and most of the time, like the phantoms in our haunted house, they disappear in the light of day.

And it concludes: "Remember—life consists of just one TO-DAY after another. The past is nice to remember—but not to brood over. The future is nice to look forward to—but not to worry over.

"TO-DAY is for living—Let's enjoy it."

The department plans a wide distribution of the booklet and will

supply quantities without charge to agencies and organizations in New York State interested in the promotion of mental health. Single copies are available free to any one anywhere. Requests should be addressed to the Department of Mental Hygiene, Albany, New York.

The Committee on Hospitals of the Group for the Advancement of Psychiatry has issued an "Outline Guide" to be used in the evaluation of treatment in a public psychiatric hospital. A few introductory paragraphs state the purpose of the publication:

"This Outline Guide is offered as one aid in the evaluation of treatment in a public psychiatric hospital. Although not intended to take the place of other weighing devices, it may be found useful as a supplementary tool. Employed as a check list, it will direct attention to many aspects of hospital operation sometimes thought of as outside the realm of treatment. Since everything associated with the comfort, basic care, and well-being of the patient is intimately connected with his therapeutic course, aspects of the hospital program relating to these matters must, in fact, be regarded as part of the total treatment process.

"The Outline should be of use to any qualified individual interested in the operation of a public psychiatric hospital, and particularly to the administrator, physician, trustee, and department head. It not only serves as one means of gauging staff achievement, but helps in the evaluation of specific aspects of the hospital program in their relation to treatment, thus stimulating the staff toward further improvements in therapy.

"Because of the variations in hospital structure, size and available appropriations, it would be difficult for all hospitals to meet each of the goals implied in this guide. Such variations must be taken into consideration in any evaluation. The present outline will fulfill its purpose if it serves as a reminder of the complex nature of hospital operations and as a guide and help in their continued improvement."

Then follow 315 questions on various phases of hospital life: food, clothing, ward living, personal hygiene, the barber shop, the beauty shop, dental care, occupational therapy, recreation, religious services, medical and surgical service, general therapy, family care, the relationship of the hospital with the community, arrangements for the care and treatment of neurological cases and cases of tuberculosis, personnel, and training and research.

Copies of the guide may be obtained at a price of 25 cents each from the Group for the Advancement of Psychiatry, 3617, W. 6th Avenue, Topeka, Kansas.

A simplified glossary of familiar psychiatric terms for professional and reference use can be obtained from the American Psychiatric Association, 1785 Massachusetts Avenue, NW, Washington 6, D. C. at a price of 50 cents.

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